STATE TITLE V BLOCK GRANT NARRATIVE
STATE: DE
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Assurances and Certification Forms are kept on file in the State MCH program's office and can be made available by request to Janet Stuart , Director of Maternal and Child Health.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Drafts of this document were shared with the Maternal Child Health Block Grant Steering Committee, which is composed of representatives from the Division of Social Services (Medicaid), Department of Education, Department of Services for Children, Youth and Their Families, Division of Child Mental Health, the March of Dimes and the Division of Public Health. It was also reviewed by the Coordinating Council for Children with Disabilities representing over forty state and private agencies. The review of the block grant was more intensive this year due to the needs assessment process. After the grant is submitted, the various reports/ surveys and needs assessments will be widely distributed to various groups including the Interagency Coordinating Council, the Rural Health Initiative, the Center for Disability Studies, the March of Dimes, and other key individuals including those parents on the various committees and boards.

Letters of Support are on file in the Maternal and Child Health Program offcie.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

The State of Delaware is located on the eastern seaboard of the United States. A small state encompassing just 1,983 square miles, Delaware ranks 49th in area among all states. Three counties, New Castle, Kent, and Sussex, cover only 96 miles in length and 35 miles in width. The states of New Jersey, Pennsylvania and Maryland, as well as the Atlantic Ocean and Delaware Bay, border the State of Delaware.
Per 2003 data Delaware's total population is approximately 792,494. The majority (56%) of the population is between the ages of 20--59. The population aged 0-19 account for another 27% and, finally, those aged sixty (60) and up constitute the remaining 18%. It is interesting to note that since 1990, children ages 10 to 14 have increased by 29%. The population estimate for Delaware for 2004 was 830,364; a four percent increase. New Castle County increased by .01%, Kent County by 3.0%, and Sussex County by 2.2%. The population estimate for Delaware for 2010 is 838,913.

The top five employers, starting with the largest, include the State of Delaware, A.I.duPont de Nemours and Company, MBNA Corporation, Christiana Health Care Systems and the Dover Air Force Base. The median income across the state is $40,009 with the per capita income at $15,854. According to the U.S. Census Bureau, in 1999, 10.4% of Delaware's population can be considered poor (less than 100% of the Federal poverty guidelines). 11.0% of all Delaware's children under 18 are poor (Three year average).

Census data shows that the state's median income grew by almost 5 percent to $47,381 from 1989 to 1999. New Castle County had the highest median income at $52,419, followed by Kent County at $40,950 and Sussex at $39,208. The median income in Sussex rose by 12.3 percent because an influx of older, wealthier, and better-educated retirees moved into beach areas. Overall, the data show significant gains in well-paying professional jobs because of the growth of service industries such as banking. However, the data also show that not everyone benefited from the decade's growth. The number of families living in poverty rose and the gap between the poor and the well to do widened. The number of families in poverty grew by 23 percent to 13,306 between the 1990 and 2000. The number of single mothers in poverty grew by 24 percent to almost 7,000 women. The percent of people in service occupations grew from 12.6 percent in 1989 to 14.6 percent in 1999. People in manufacturing jobs dropped by about 21 percent to about 12.5 percent. However, the new census figures show that the number of people in upper incomes grew in the past decade while the percentage of families in poverty also increased. In 2000, 63,663 Delaware households, or 21 percent, reported an annual income between $50,000 and $74,999, making that income groups the largest. In 1989, the largest percentage of the state's households - 20 percent - fell into the $35,000-to-$49,999 range. When adjusted for inflation, that range translates to Census 2000's $45,425-to-$64,892 bracket.

Between 2000 and 2001, the Division of Public Health pulled together a statewide partnership of over 150 Delawareans from business, community, health care, education, and government organizations to create the Healthy Delaware 2010 Initiative. A multi-sector steering committee established the vision and goals for the initiative and a collaborative process to develop measurable health improvement objectives for the decade. At the end of the process, over 60 private and public sector partners agreed to become "Prevention Partners" to involve their organizations, staff and members in the development and promotion of Healthy People 2010; work towards the achievement of health for all Delawareans; and be active partners in the initiative. Several of the objectives and strategies of Healthy Delaware 2010 are in the MCH plan and are so referenced throughout this application.

Geographic Disparities
Although the state is relatively small, disparities exist across the counties with regard to access to

quality health care services. Some of the problems are predominantly found in certain areas while others are common in each of the counties. For example, while it takes less than three hours to drive from one end of the state to the other, transportation is among the worst of the problems in each of the counties. Coupled with the geographic distribution of primary care physicians and dentists, this results in critical access issues. Racial, cultural and language barriers lead to access problems and place added burdens on the system.

Sussex County is the poorest in the state with an estimated 30% of its residents below 200% of the federal poverty level as compared to 23% for the rest of the state. The unemployment rate is also higher and the average income about $8,000 less than the state average. Key informants note several communities in Western Sussex and south of Georgetown that have particular difficulties in accessing care including Frankfort, Clarksville, Selbyville, Hickory Tree, Seaford, Laurel and Bridgeville.

Places in Delaware other than the city of Dover, Kent County, while much smaller than Sussex County, is also mainly rural. Because of its population size, the county has been precluded from the benefit of federal designations necessary for eligibility into many federal programs. Kent County has had the lowest access rate to prenatal care in Delaware. Overall health services in the rural part of the state are more limited in availability when compared to northern New Castle County.

The city of Wilmington is like most urban areas throughout the nation and has correspondingly high rates of teen pregnancy rates, infant deaths, children born to single mothers, juvenile arrests and AIDS cases. Kids Count produced a fact book for the City of Wilmington and for the State of Delaware with a volume of data and trends related to Maternal Child Health. The City had a Public Health Officer for one year and the funding was cut. At the time there was a health consultant on board and she continues to be on contract directly to the Mayor's Office. Her role is to organize and guide the Mayor's Health Planning Council. The Council has been in existence for about six years. The consultant also organizes the Mayor's health initiatives, like his Healthy Walk with the Mayor monthly, the AIDS forum annually, the Wilmington Wellness day event and other activities of the Council. Areas of focus for Wilmington include: access to preventive care, chronic disease prevention, HIV/AIDS, mental health, responsible sexual behavior, substance abuse and violence prevention

Racial Disparities between whites and blacks:
The Office of Minority Health for the Division of Public Health released a report on Health Disparities in Delaware in March of 2001. A version of the document in Spanish was released in the fall of 2001. The following findings are significant:
There were three indicators where the rate for blacks was 3 times higher or more than the rate for whites: HIV Infection/AIDS Death Rate (10.66), Homicide Rate (4.3), and Asthma Hospitalization (3.3).
Five indicators showed a disparity ratio of between 2 and 4: Teen Birth Rate (2.71), Late or No Prenatal Care (2.55), Per cent of Low Birth Weight Births (2.08), Infant Mortality (2.75), and Diabetes Death rate (2.47).
Four indicators had a disparity ratio between 1 and 2: Alcohol-Induced Death rate (1.64), Stroke Death rate (1.62), Cancer Death Rate (1.45) and Heart Disease Death rate (1.20).

The Office also analyzed trends and determined that long-term downward trends were significant for late or no-prenatal care and alcohol-induced death rate. Trends have decreased in the short term for low birth weight births and teen birth rates. However, for all other indicators the disparity ratios have either changed or worsened.
On May 31, 2005 the Honorable Governor Ruth Ann Minner signed the Executive Order Number Sixty-Eight which established the Health Disparities Task Force. The Family Health Section, along with the Maternal and Child Health Branch and the Adolescent and Adult Health Branch, will be key participants in the Health Disparities Task Force. The goals of the Task Force include: defining the health disparities status of Delaware as compared to the nation and the region; documenting the disparities among racial and ethnic groups related to specific conditions and the reasons for the gaps; identifying best practices for prevention and intervention; increasing awareness of the scope of the

problem among government officials, medical professionals and the public; improving coordination between and among the public and private sector; and identifying areas requiring additional research and education.

What are the State Health agency's current priorities and initiatives? The mission of the Division of Public Health (DPH) is to protect and enhance the health of the people of Delaware by:
• Addressing issues that affect the health of Delawareans
• Keeping track of the State's health
• Promoting positive lifestyles
• Responding to critical health issues and disasters
• Promoting availability of health services

Current DPH MCH related priorities include:
• Decrease infant mortality with a special effort to eliminate the disparity between white and black infant mortality
• Prevent teen pregnancy
• Improve the rate of immunizations
• Reduce the use of tobacco
• Develop a support system for CSHCN
• Prevent childhood lead poisoning
• Improve understanding of health and safety issues for child care providers
• Address adolescent needs through School-Based Health Centers
• Develop a comprehensive early childhood system
• Establish an emergency preparedness system
• Eliminate racial and ethnic health disparities

How did the Title V administrator determine the importance, magnitude, value, and priority of competing factors upon the environment of health services delivery in the State? The Title V administrator used a variety of sources to analyze the competing factors, which affect health services delivery. In particular, a needs assessment was completed based on parent surveys and focus groups, community needs assessments, discussions with key stakeholders, and reviews of reports and analyses. The draft was shared with several community groups (Delmarva Rural Initiative, Perinatal Board, Part C Interagency Coordinating Council, Healthy Start, etc.) and interested persons. After the draft was distributed, meetings were held in all counties and recommended changes were incorporated into the document. For this year's application, the Title V administrator requested updates from the key participants who contributed to the development of the needs assessment.

B. AGENCY CAPACITY

Steps Taken by the CSHCN Program to Ensure a Statewide System of Services:

• State Program Collaboration with Other State Agencies and Private Organizations

The state collaborates with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

The responsibility for providing direct care and services for children from birth to twenty one years of age falls to more than one agency. Coordination of service delivery within the present system is the

key issue. There are numerous providers involved and communication is not always consistent. For children birth to three, the Division of Public Health works closely with several state agencies to ensure collaboration in the continuation of a statewide, comprehensive, coordinated, multidisciplinary, and interagency service delivery system for infants and toddlers with disabilities and/or developmental delays who are eligible under Part C of the Individuals with Disabilities Education Act (IDEA). The Director of CSHCN is responsible for the Part C operations in the Division of Public Health.

The Delaware Coordinating Council for Children with Disabilities (CCCD) has been active as an advisory committee for the CSHCN program. This has increased both the formal and informal interagency collaboration statewide. In addition, the CCCD has received technical assistance from Health Systems Research, Inc. who has initiated a technical assistance plan for the CCCD with a focus on interagency, collaboration, communication, and assessment. A final needs assessment as an outcome of the Technical Assistance Plan is expected to be completed by Health Systems Research, Inc. and will be used as a basis for the Maternal Child Health required needs assessment process for CSHCN.

Numerous representatives from the Division of Public Health participated in Delaware's Continuous Improvement Monitoring Process. The Office of Special Education Programs (OSEP) of the U.S. Department of Education is responsible for assessing the impact and effectiveness of State and Local efforts to implement the mandates of the Individuals with Disabilities Education Act (IDEA) amendments of 1997. "The Continuous Improvement Monitoring Process" is the title given to the process by which impact and effectiveness are determined. As part of this process, Delaware was chosen as one of 16 states to conduct a statewide self-assessment regarding the provision of Early Intervention and Special Education services in the state. The self-assessment was intended to identify both strengths and areas of improvement and compliance issues of the State's Part B and Part C programs for children birth to 21. There were three phases of the self-assessment process, which began in June 2000: 1) Review of the data and the development of the draft self-assessment; 2) The Validation Process; and 3) Review of the public input and finalization of the self- assessment report.

Title V provides leadership and some funding for services having to do with children with special health needs in the state. Other private and public agencies also have a lead role affecting this population. Among them are other agencies in DHSS, specifically Medicaid, and the Birth to Three Office in the Division of Management Services, the Division for the Visually Impaired, and the Division of Developmental Disabilities Services. The Division of Child Mental Health, Department of Services for Children, Youth, and Their Families has the primary lead on child mental health and substance abuse issues. The Department of Education ensures that CSHCN are provided with a free appropriate public education. A major private provider is the duPont Hospital for Children, which also administers pediatric clinics. There are also numerous private therapy providers. Goals for children with special health needs cannot be met without the collaboration of these groups. The Delaware Department of Education in collaboration with numerous other agencies and departments, including the DHSS and the DSCYF sponsored annual statewide Early Childhood Summits. The summits have focused on a strategic planning process to address the emotional wellness in young children inclusive of CSHCN. Most recently the Nemours Foundation has established a Division of Preventive Services. One of their three priorities is the emotional health of children including CSHCN. A final consensus report is due year end 2005.

As a result of a needs assessment conducted by the Part C program, a Speech Summit was held to raise the awareness and to formally continue the discussion on the appropriate and effective use of the increased demand for speech and language therapy services in Delaware. The National Early Childhood Technical Assistance Center facilitated the process. A strategic plan was formulated to address the future needs of the CSHCN and their families. That strategic plan is being implemented with new guidelines created and approved under a program called "Enhanced Watch and See". The program addresses speech and language therapy services statewide.

• State Support for Communities
State programs strive to emphasize community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

The State provides support for the development of community-based service programs for CSHCN through:
1) The Medical Home Initiative, 2) the Traumatic Brain Injury Project, 3) the Autism project, and 4) Partners in Policy Making.

Medical Home: The Office of Children with Special Health Care Needs in partnership with the Medicaid Office, the Delaware Chapter of the American Academy of Pediatrics and Family Voices has developed a Medical Home Model to provide care coordination for CSHCN. A Community Access to Child Health Planning (CATCH) Grant provided funding for training of State and community service providers in the Medical Home Model. In addition, the concept of the medical home has been added to the Medicaid Request for Proposals for managed care organizations. A small CATCH grant was submitted by the Delaware AAP in conjunction with the CSHCN program and was approved. The grant had planned to implement a "certification" process for medical homes focusing on pediatrician and family practice offices. Due to systems issues, the process was never completed. To continue to address the issues, the Medical Home initiative has partnered with the Medical Home subcommittee of the State Early Childhood Comprehensive Systems planning grant. The merging of the two committees has enhanced its membership and its productivity.

Traumatic Brain Injury: The Director of Children with Special Health Care Needs has provided active representation on two statewide initiatives addressing traumatic brain injury. The state support for TBI has shifted systemically to the State Council for Persons with Disabilities. There now is an active a Brain Injury Committee (BIA) of the council, which coordinates the efforts related to TBI/ABI. The Director of CSHCN remains an active member of the committee which addresses both treatment and prevention efforts. The committee includes major participation of parents and young adults with BIA. A major accomplishment of the BIA has been the legislation of TBI as a category for special education services within the Department of Education. The local school districts are now required to report on every child with a diagnosis of TBI which will ultimately effect the range of services afforded to those children and families.

Autism: The Autism Surveillance Project complements the work of the CSHCN Advisory Committee. The data that the project collected and analyzed is used to contribute to the formulation of a state policy on autism, inform discussion of the fiscal resources needed and possible funding mechanisms, facilitate service planning and implementation and allow for the evaluation of the service program. The surveillance project measured the population prevalence of these disorders, breaking down surveillance by subtype, and tracking the prevalence over time. Maryland will compare its population and experience with that of Delaware. The Director of CSHCN is on the Autism Project Advisory Committee. The Maryland/Delaware Autism Surveillance Project expanded into a Center of Excellence called the "Center for Autisms and Developmental Disabilities Epidemiology". Under its monitoring activities, the number of children living in Maryland and Delaware with an ASD is not known. However, we do know that during the 2002-03 school year two hundred seventy eight (278) children ages three to eleven years, in Maryland, we classified as having autism under the Individuals with Disabilities Education Act (IDEA). There are additional children with ASDs who are classified in other disability categories under IDEA or who do not receive special education services. The center used multiple sources to obtain a more accurate estimate of the number of children in the study area with an ASD. The monitoring activities focused on children eight years old.

In a major initiative supported by the Coordinating Council for Children with Disabilities, the regulations for House Bill 500 (passed in July of 2004) were supported. This bill required DHSS/DPH to establish and maintain an Autism Surveillance and Registry Program for the purpose of establishing a central data bank of accurate, precise and current information regarding autism in the

State of Delaware. DHSS/DPH was required to adopt regulations requiring health care providers to report of every occurrence of autism in the State of Delaware.

• Coordination of Health Components of Community-Based Systems
Two DPH programs help to coordinate health and community-based systems for CSHCN, Kids Kare, and the Ryan White Program.

Kids Kare: The Division of Public Health provides a multi-disciplinary support program for vulnerable families with children who have been found to be biologically, nutritionally, psychosocially, or environmentally at risk, factors that are highly correlated with a probability of delayed development. A care plan is developed based on the needs of the family determined by risk factors identified at an initial home visit assessment. The families receive support, teaching, and coordination of services in their home from Public Health nurses, social workers, and /or nutritionists. Services are available for low-income families who have Medicaid or who are uninsured. Children up to the age of 21 may be referred but priority is given to those children who are between the ages of birth to six. Children referred to this program may show signs of developmental delay but do not meet the eligibility requirements for the Part C program. An evaluation of the Kids Kare Program is ongoing, with results due in the fall of 2005.

Ryan White HIV program: The Division of Public Health also manages Ryan White Grant funds, which provide case management to a small number of HIV infected children (29 children). The case manager is housed in the A.I.duPont Hospital for Children. Case management is focused on the health care needs of the child to ensure that medical services are provided through an infectious disease specialist, primary care physician, and dentist. HIV positive and negative children are also provided services if they live in a family unit where at least one of the parents is HIV infected. These may include, case management, food, housing, emergency financial, transportation, and other forms of assistance. There is also an AIDS Medicaid Waiver provided to children who are AIDS diagnosed (total 10 children). The Wavier provides the full range of Delaware Medicaid services along with Waiver specific services of case management, respite, and nutritional supplements. Also, Christiana Care Health Services receives Ryan White Title IV dollars which supplement the Title II activities enhancing the case management and follow up activities with women who are identified as HIV infected or at high risk of infection. There is about a ten percent (10%) increase in persons who access Ryan White services overall, but there is not the same increase related to children. We have not had an infant born HIV infected in the past two years. This is due to mandated counseling and voluntary testing activities at the OB-GYN offices. Also, if a woman is at Labor and Delivery and does not have an HIV result on her chart she will be rapid tested for HIV and if positive started on HIV prophylaxis.

Some coordination is offered for mental health services as described below:
Mental Health: Children and adolescents under the age of eighteen who receive Medicaid or are uninsured are served by the Division of Child Mental Health Services (DCMHS) in the Department of Services for Children, Youth, and their Families DSCYF DCMHS offers essentially all types of mental health and substance abuse treatment options. These services include: early intervention, crisis services, outpatient, wraparound, intensive outpatient, partial day treatment, day treatment, day hospital, residential treatment, and psychiatric hospital services. In order to promote incorporation of mental health services into primary pediatric care, and to discourage early referrals and institutionalization, private organizations paid for by MCOS furnish 30 units of non-residential mental health services for children. After the 30 units have been exhausted, or on passing a DCMHS assessment for acuity, clients can enter service with DCMHS.

DCMHS also offers extensive services to homeless children. Referrals come from the Division of State Service Centers, Public Health clinics, Head Start, and schools. Most referrals have originated from shelters to the Crisis Services of DCMHS.

The Division also has worked with hospitals to provide on-site emergency room training in appropriate

response to mental health emergencies. Specific interrelationships with education include: Membership in the Interagency Collaborative Team (ICT) for funding rare and complex students, participation in Interagency Coordinating Councils to develop a model of integrated services between mental health and education, provision of mobile crisis services to the school and training in using the crisis services. In addition, the School/ Agency Collaboration use a team approach to identify and develop solutions around specific children and families. The initiative calls for school based student support teams that are responsible for case planning and management for service delivery. The team leader serves directly as a liaison to a district-level support team and to the Family Services Cabinet Council agencies. The district level support teams assist the school based teams, state and community agencies in resolving problems, coordinate training, develop policy to ensure consistency across the district, appoint a single point of contact between the district and the agencies, and assess effectiveness. The Division additionally collaborates with the Department of Education through participation in the State System of Care Team, which is comprised of public and private agencies, families and other advocates.

A Mental Health Shortage Designation Committee has been established in 2005 and includes representatives from the Division of Public Health, the Division of Substance Abuse and Mental Health, the Health Care Commission, and the Division of Child Mental Health. The Committee will be studying the capacity of the systems to address the mental health needs in the state, including children. Projects range from a mental health clinician capacity study to focus groups for both providers and consumers. There are five mental health objectives listed in Healthy Delaware 2010.

• Coordination of Health Services with Other Services at the Community Level

Various mechanisms exist in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Special Education:

About 6 months prior to turning three, the Part C eligible child is referred to a school district Child Find. Referrals with parental permission can come from the CDW service coordinator, primary care physician, relatives, childcare providers, or other professionals. CDW service coordinators work with the school district, parents, and private service providers to establish a transition meeting. The purpose of the transition meeting is to discuss how a child is progressing in his current program. This may include the review of past and present services; discuss the adequacy of those services in meeting the child's needs; explore the possibilities for future services, both short and long term; and determine what if anything needs to be done (site visits, immunizations, etc.) to prepare for preschool.

Delaware carries out Public Law 94-142, Public Law 99-457, and Title 14 of the Delaware Code through its Administrative Manual: Programs for Exceptional Children. This manual states that all eligible students with disabilities are entitled to a free, appropriate public education. A free, appropriate public education is defined as specialized instruction and services, including related services that are designed to enable persons with disabilities to benefit from education. The majority of the schools provide services for children aged three to twenty-one years (3 to 21). However, four categories have been given special status (by legislative mandate) and receive services at birth. "Birth mandate services" are provided from birth to 21 for children who are autistic, deaf-blind, deaf, and blind. Each school district has a Multidisciplinary Team (MDT), which initially determines a child's eligibility for special education services.
Family Support:
Family Forums offer a way to reach out to families statewide, and include monthly meetings throughout the state and address a variety of issues. Typical topics presented this past year include a series of sibling workshops, several sessions on parenting and coping skills, and a session on sensory integration. These Forums are open to families with children birth to kindergarten. Outreach to families is coordinated with the Parent Information Center of Delaware, Delaware's Parent-to-

Parent Center. Family Resource Rooms have been set up at each Child Development Watch site as a resource to both staff and families. User-friendly manuals, including listings of books, videos, parent-tips and handouts, are available. The Program also developed an Internet Guide titled, "Children with Special Needs, Internet Guide for Parents and Professionals".

Delawareans with Special Needs: Medicaid Managed Care Panel is a group of parent advocates who meet on a monthly basis with members of the Delaware State Medicaid Office, representatives from the Health Benefits Managers Office, and the two Managed Care Organizations who make up Medicaid's Diamond State Health Plan. Each month a variety of issues are addressed. The meetings are designed to provide a place where people can come to address specific issues or complaints about Delaware's Medicaid Managed Care programs and its providers; give members assistance in learning about the different types of plans available through the Diamond State Health Plan; and give participants opportunities to learn about Medicaid and keep up with changes.

The Parent Information Center provides state wide services that include; educational advocacy training for parents of children with disabilities; individual technical assistance for families and professionals; information on special education laws and processes; information on the rights and entitlements of persons with disabilities; information on various disabilities; information and training for professionals working with children and youths with disabilities and their families; and disability awareness training and events for schools and community. Resources available at the Center include books, news articles, and videos. The Parent Information Center also provides programs that include individual technical assistance programs; parent educational advocacy programs; and parent-to-parent support.

State Statutes Relevant to the Title V Program

Below are the state statutes relevant to children and families served under Title V:
Child restraint and bicycle safety laws help to support the Title V priority need to reduce preventable injuries to children and adolescents.
• Every person transporting a child under the age of 4 years in a motor vehicle is responsible to secure a child in a child-passenger restraint system.
• Children between the ages of 4 and 16 are required to wear a fastened seat belt or child passenger restraint system at all times while in a motor vehicle.
• No child who is 65 inches or less in height and under twelve (12) years of age shall occupy the front passenger seat of any vehicle, which is equipped with a passenger-side airbag that has not been deliberately rendered inoperable.
• Children under 16 years of age must wear a properly fitted and fastened bicycle helmet when operating, riding upon, or riding as a passenger in any bicycle.

Immunization requirements for entrance to schools and day care centers support the Title V performance objective of averting cases of vaccine- preventable morbidity and mortality.
• All children enrolling in the public schools should have at least begun the series of immunizations not later than the time of enrollment.
• The Department of Health and Social Services is authorized to prevent and control the spread of vaccine-preventable diseases in children, including regulation of nonpublic elementary and secondary schools and childcare and other preschool facilities.
• The Department of Education regulations have been updated to require varicella for entry into kindergarten.

Birth certificates -- The registration of all births in Delaware is required by law. Confidentiality is ensured. The data collected helps to support the Title V data requirements and objective tracking.

Trauma Registry helps the Title V agency to better plan for services for children with disabilities caused by trauma. Acute care facilities that transfer trauma patients with moderate or severe injuries

to Trauma Centers contribute data to the Delaware Trauma System Registry and Quality Improvement Program.

Mandatory reporting of certain notifiable diseases to the Division of Public Health effects all providers including Title V providers such as School-Based Health Centers and Public Health Clinics. Included are several laws pertaining to the reporting of STDS and lead poisoning

Childhood Lead Poisoning Screening supports the MCHBG state performance objective #4 to ensure that all Medicaid eligible children are screened for high lead levels.
• Every health care provider who is the primary health care provider for a child is required to order screening of that child, at or around 12 months of age, for lead poisoning.
• This law requires that all group and blanket insurance policies that provide a benefit for outpatient services shall also provide a benefit for a baseline lead poisoning screening test for children at or around 12 months of age. Benefits are also to be provided for lead poisoning screening and diagnostic evaluations for children under the age of 6 years who are at high risk for lead poisoning.

Establishment of Birth Defects Registry documenting every diagnosis or treatment, or both, of any birth defect in any child under age 5 in the state.
• The intent of the General Assembly is to provide financial assistance for the treatment of children with birth defects and to require the establishment and maintenance of a birth defects surveillance system and registry for the State. This is the law that established the provision of the Special Formula fund.
• Certain health care practitioners and all hospitals and clinical laboratories are to make available to the Department of Health and Social Services information contained in the medical records of patients who have a suspected or confirmed birth defect diagnosis.
• Although this law has been in effect for several years (regarding the actual reporting of the birth defects), the registry is still in the process of being established as a data tracking system.

The Autism Surveillance and Registry System is the outcome of the regulations as established for House Bill # 500 mandating
such a system (16 Del.C.,Sec 223) . The Autism Surveillance and Registration Program Regulations will require health care practitioners to report information on children under 18 years of age with autism to a central Autism Registry. Information collected in the Autism Registry will be used to track changes in prevalence of autism over time, to inform the planning of service delivery to children with autism and their families, and to facilitate autism research.

Services for Children with Disabilities are also established through the Delaware Code. The Department of Health and Social Services is designated as the agency to administer a program of services for indigent children who are "crippled or who are suffering from conditions which lead to crippling." This program is minimally funded, but has helped support the Specialty Clinics in Southern Delaware.

Mandated insurance coverage for PAP tests, mammography, immunizations and blood lead screening supports preventive health goals of Title V.

Infant and Toddler Early Intervention Services Act authorizes Part C of the Individuals with Disabilities Education Act (IDEA). This Act ensures services for birth to three-year-old infants and toddlers who have developmental delays or disabilities or a high probability of delays under our Child Development Watch program.

The Child Death Review Commission is also established through law. This Commission reviews deaths of children under the age of eighteen (18) years of age, to provide recommendations to alleviate those practices or conditions, which affect the mortality of children. The legislation has been amended to include child death, near death and stillbirth.

The State's Title V Capacity

The Division has been attempting to shift from providing direct health care services. To return to the basic functions of public health: assessment (collecting and analyzing information on the health and health needs of communities), policy development (developing public health policies based on sound scientific knowledge and principles), and assurance (committing to constituents that services needed to achieve health goals are available). Theoretically, the affect of managed care and increased involvement of the private sector (i.e., A.I.duPont Pediatrics, Healthy Start) should have made it possible for Maternal and Child Health leadership to reemphasize the core values by supporting infrastructure building and population based services. However, since Title V funding was originally targeted to provide direct services provided by the counties and tied to personnel, it has been extremely difficult to reallocate those resources.

Based on this year's realignment, Maternal Child Health issues are administered through the Family Health Section (previously called Community Health Care Access Section). As of November 2004, the Section Chief is Dr. Herman Ellis, DPH Medical Director. The Section consists of two Branches: Maternal and Child Health Branch and the Adult and Adolescent Health Branch. Northern and Southern Health Services and Health Systems Development are each their own Sections now and are also under the direction of Dr. Herman Ellis. Dr. Ellis is responsible for 5 Sections. Also Special Populations (WIC) and Health Systems Development have been moved to the Health Promotion and Disease Prevention Section.

Title V is administered by the Maternal and Child Health Branch of the Family Health Section. Janet Stuart was appointed the Maternal and Child Health Branch Chief (Title V MCH Director) in May 2005. The Branch includes Newborn Screening, Child Care, and Children with Special Health Care Needs and the administration of the MCH Block Grant.

Dennis Rubino resigned his position as the Children with Special Health Care Needs Director in May 2005. This position is currently vacant but is in the process of recruitment. Mr. Rubino continues his responsibilities for CSHCN until a replacement is found.

Dennis Rubino is now the Chief of the Adult and Adolescent Branch of the Family Health Section. This Branch includes Family Planning, Adolescent Health (teen pregnancy prevention and School Based Health Center programs), and Office of Women's Health.

The Family Health Services Section works in concert with the Health Systems Management Branch which includes a Primary Care Coordinator, Kathleen Collison, funded through Title V funds. Ms. Collison has the responsibility to work with other DPH programs, to plan, develop, and implement MCO prevention partnerships. Also to develop an evaluation plan relating to Public Health core functions, coordinate and oversee the development of an annual report of services paid for by DPH under Medicaid managed care. She also works to problem solve MCO billing issues; work with the FQHCs regarding managed care issues; promote DPH specialty services in the private sector; and oversee biannual capacity studies of primary care physicians, dental services and specialist physicians.

C. ORGANIZATIONAL STRUCTURE

Delaware's public health system includes both the state and local functions in the same state agency administered as a single unit--the Division of Public Health (DPH). The Division is one of 11 divisions under the umbrella agency Delaware Health and Social Services (DHSS). The DHSS Secretary, Vincent Meconi, reports directly to the Governor. Delaware began year 2001 with a new administration under Governor Ruth Ann Minner. Several officials were replaced and since the current fiscal situation is not as positive as in past years, there are few new initiatives.

The budget situation has deteriorated over the last years. The economic situation has ranged from the Governor ordering a freeze on hiring for most state jobs other than those providing essential services,

such as police, prison guards or nurses to federally funded positions being frozen. Currently there is no freeze on positions but each request to hire must be justified and approved on a position by position basis.
Due to level funding of the MCH Block Grant (MCHBG), there are 6 positions on the MCHBG that are frozen. Five of these positions are direct care positions that will impact the number of MCH clients that can be seen within the year. In the last several years, the MCHBG grant funds have been level funded which translates into a decrease of funds when salaries and benefits are increased. If additional funds are not received then more positions may need to be frozen in the future which will continue to negatively affect direct care services to the MCH population.

It is important to point out that in Delaware, the MCH Block Grant is used almost exclusively to support staff positions that are assigned to work out of the local health units. All but five of those positions are assigned to the two local health units, Northern and Southern Health Services, and are responsible for service provision at the local level. As evidenced by Delaware's overmatch of its Title V funds, funding from a variety of sources including revenue, State funds and other Federal dollars, provide the majority of support for the State's maternal and child health programs. Other maternal and child health related programs such as immunizations, breast and cervical cancer, and childhood lead poisoning are located in other sections of Public Health making them further removed from the Title V program. Consequently, it is very difficult to describe the Title V funded efforts as distinct from the many maternal and child health efforts and programs being offered statewide.
Due to this year's realignment, the administration of the Maternal and Child Health and Children with Special Health Care Needs programs, are provided through the Maternal and Child Health Branch of the Family Health Section. This Branch includes infant mortality issues, child health, and Newborn Screening. The School Based Health Center program has been moved to the Adult and Adolescent Branch of the Section that also includes family planning, Adolescent Health and Office of Women's Health.
The Maternal and Child Health Center for Excellence has been established as a ‘virtual' office based in the MCH Branch. The core group includes many of the staff in the Family Health Section, with additional experts from other sections and divisions. A MCH Epidemiologist has been recruited and is to join the Center in August, 2005. The chair of the Center for Excellence is the MCH Director.

Attached are the organizational charts for the state government, DHSS, DPH, and Family Health Services Branch

D. OTHER MCH CAPACITY

Direct and population based services are primarily provided through Northern and Southern Health Services. Services for CSHCN are coordinated through Northern and Southern Health Services but are primarily focused on children birth to three and those at-risk. There are close to 34 positions that are funded through Title V. Most of these positions are those working in the local health units. Leadership for the local health units is provided by Anita Muir for Northern Health Services and Barbara DeBastiani for Southern Health Services. Based on this year's realignment, the Community Health Care Access Section is now called the Family Health Section. Maternal and Child Health issues are addressed under the Family Health Section, Maternal and Child Health Branch. Northern and Southern Health Services and Health Systems Development are their own Sections. The four mentioned Sections work under the direction of Dr. Herman Ellis, DPH Medical Director.

Attached is a map of the public health clinics.

Managing Data: The capacity to manage data and evaluation is limited within the Title V state office. To address this limited capacity, we work very closely with the Division's Health Information and Epidemiology Section to obtain the needed data for our programs. Personnel from this office serve as the AMCHP Data contact, serve on the MCH Block Grant Steering Committee, and are key contributors to the process.

Other DPH sections: Two other sections which impact on MCH issues are Health Promotion and Disease Prevention (HPDP) and Health Systems Management (HSM). HPDP is responsible for prevention programs such as Cancer, Diabetes, Tobacco, HIV, etc. HSP is responsible for environmental health, which includes lead poisoning prevention. The HSM includes SSDI, primary care, and rural health.

The Office of Emergency Medical Services of the Emergency Medical Services Section, has coordinated with MCH, including CSHCN, regarding issues around emergency preparedness for children and with injury prevention. A Special Needs Alert Program has been activated to link CSHCN with the 911 system and the first responders within their community. There are four objectives related to injury and disability in Healthy Delaware 2010.

Title V also works with Delaware's Office of Emergency Medical Services, particularly with its Emergency Medical Services for Children program.

E. STATE AGENCY COORDINATION

Delaware as a small state has many benefits, one of which is the greater ease of collaboration with a number of private and public agencies to address the maternal and child health needs of the state. Title V, Division of Public Health works with all agencies, foundations, and constituency groups to assure that pregnant women, mothers, infants, children, adolescents and children with special health needs and their families receive the best quality service available.

Delaware Health Care Commission:
The Delaware Health Care Commission is an independent public body that reports directly to the Governor and the General Assembly. It was established by the General Assembly in 1990 to develop a "pathway to basic, affordable health care for all Delawareans". The Health Care Commission has focused on several initiatives designed to increase access to healthcare for uninsured and underserved Delawareans, including the Community Healthcare Access Program, the State Planning Program, and an analysis of the safety net in Delaware. The Health Care Commission also convened a committee around mental health issues and published ‘The Committee on Mental Health Issues Final Report.'

Department of Health and Social Services: The Division of Public Health (DPH) resides in Delaware Health and Social Services. Included in the Department are several agencies, which work closely with DPH. They are:

The Delaware Medicaid Office is administered by the Division of Social Services. Under Delaware's Medicaid program there are two Medicaid Managed Care Organizations (MCOs) and Delaware Healthy Children Program (DHCP), Delaware's SCHIP program. DPH works closely with DE Medicaid on a variety of issues, including access to health care coverage and medical homes for all children, including those with special health care needs, and pregnant women, oral health access, prenatal care access, Child Development Watch operations, and early childhood systems development. To date, 139,187 Delaware residents receive Medicaid services and 10,825 children are currently enrolled in the DHCP program.

The Division of Social Services, Child Care Office manages the child care services to support families with young children to enable the caretaker to hold a job, obtain training or meet special needs of the child. Child care may also be provided in child abuse cases to help protect the child. The service is available for children from infancy through twelve years of age. DSS determines eligibility based on the need for service and income. The income limit is currently set at 200% of the Federal Poverty Level (FPL). DPH and DSS-Child Care Office have partnered to ensure that health and safety standards in all licensed child care centers and home statewide are improved through training,

technical assistance and regulations. The DSS-Child Care Office is assisting DPH with funding to support the statewide network of child care health consultants in the coming fiscal year.

The Division of Developmental Disabilities Services (DDDS), DPH collaborates with DDDS on Traumatic Brain Injury issues, respite care, and Child Development Watch operations. The DDDS provides an array of services for individuals with mental retardation and other specific developmental disabilities and their families, who meet eligibility criteria. This agency is currently partnering with DPH and other community partners to pilot universal developmental screening of all children under the age of five.

The Division of Substance Abuse and Mental Health (DSAMH), DPH works with this agency on women's health issues, planning a women's health conference, and infant mortality issues. There are five objectives related to alcohol and drug use in Healthy Delaware 2010.

The Division of State Service Centers, DPH has worked with this agency to improve the following programs designed to assist Delawareans, most in need and link to the appropriate community or state resources:
1. The Delaware Helpline provides toll-free information and referral for persons seeking information about public and non-profit services.
2. Dental Transportation Services, in cooperation with the Delaware school system, ensures that school-aged eligible low-income children are transported from school to dental clinics located in the state service centers
3. Adopt-a-Family is a statewide program that aids families in crisis --- those struggling with illness, homelessness, domestic violence, poverty or unemployment. This year they partnered with DPH to include Back to Sleep and SIDS information to pregnant women and families with children under the age of one. They also partnered with DPH to provide Medicaid/SCHIP information to all families receiving school supplies for their children in the Fall of 2004.
4. Kinship Care Program provides assistance for relative caregivers during the 180-day transition period when a child first moves into the non-parent caregiver's home. The program assists in meeting the child's immediate needs for clothing, shelter, health, safety, and educational supplies.
5. Car seat loaner program provides car seats to needy families.

The Division of Management Services, This agency provides human resources, budget development, and evaluation services to other DHSS divisions. It also houses the Birth to Three Office, which provides administration for Part C.

TheDivision for the Visually Impaired, DPH Child Development Watch works with DVI to provide service coordination for children with visual impairments or who are deaf and blind.

The Division for Aging and Adults with Physical Disabilities, This Division has the lead for Traumatic Brain Injury issues in the state. The CSHCN Director works closely with the Division to ensure that the needs of children are addressed. DPH has also worked with this division on a variety of initiatives for older women. Although the Division for Aging and Adults with Physical Disabilities maintains the lead for the adult TBI issues in the state, the Division of Public Health, CSHCN, is working through a Subcommittee of the Council for Person with Disabilities to address the pediatric TBI/ABI issues. The Division for Aging and Adults with Physical Disabilities has gained approved for a Traumatic Brain Injury Medicaid waiver for the adult population.

Department of Education (DOE): The Delaware Health and Social Services, and the Department of Education work collaboratively to develop programs promoting the health of children in Delaware. Examples include the delivery of EPSDT services in the school setting and in providing support for School-Based Health Centers. The Department of Education (DOE) has also collaborated with DHSS in development of the Part C early intervention efforts. Staff are also housed and incorporated into the CDW team and serve as liaisons for transition and Individuals with Disabilities Education Act (IDEA B and C) issues. This year the Office of Health Services, DOE, in partnership with the DPH to provide training to school nurses on teen pregnancy prevention, lead poisoning, tuberculosis, immunizations,

and public health resources. Delaware has a comprehensive system of school nurses, with one in each school and most private schools. There are over 300 full and part time school nurses in Delaware that serve students in public and private schools. The Department of Education and the Division of Public Health have also in partnership, to provide training to the school nurses on bio-terrorism and emergency preparedness.

The Department of Education's Early Care and Education Office is a key collaborator with the Division of Public Health on the early childhood comprehensive systems effort. Initiated in 1998, Early Success was developed as the state's coordinated plan to address the early childhood issues of children, birth to eight, who received out of home care. The governor established an interagency resource management committee made of the cabinet secretaries from the Department of Health and Social Services, Department of Services to Children, Youth and their Families, Department of Education, Office of Budget, and the Controller General's Office. Additionally, the governor established the Delaware Early Care and Education Council, comprised of private citizens, and the Office of Early Care and Education (OECE) to ensure that Early Success goals and objectives were met. In an effort to provide a comprehensive approach of early childhood services to all families, the ECCS and the OECE, with full support from the Delaware Early Care and Education Council, have partnered to unify Delaware's early childhood initiatives and broaden the initial Early Success plan to include child health, social-emotional development, and expand family engagement domains. This will provide a statewide strategic plan that is comprehensive, coordinated and accessible to all children, birth to five, and their families. It will also enable the Division of Public Health to provide statewide leadership on child health and development issues through multiple public/private collaborations.

The DOE-Head Start State Collaboration Office and the Division of Public Health have also partnered under the Healthy Child Care America and ECCS projects to pilot the Partners in Excellence: Promoting Social and Emotional Competencies in Young Children (PIE) project in 15 Head Starts, ECAPs and child care centers statewide. The purpose will be to develop and utilize evidence-based social-emotional classroom strategies to promote resiliency and foster appropriate social-emotional well-being in young children.

Department of Services for Children, Youth, and Their Families: The Department of Services for Children, Youth, and Their Families (DSCYF) was created in 1983 to consolidate child protective (Division of Family Services, DFS), child mental health, and juvenile correction services within a single agency. CHCA has maintained a cooperative relationship with this agency for joint planning of services. A Memorandum of Understanding (MOU) between the DPH and DFS establishes uniform criteria for responding to reports of abuse and neglect and delineates the responsibilities of DPH and DFS personnel. The MOU addresses the need for ongoing, collaborative training and joint case planning between personnel in each agency. DFS and DPH are co-located at several local sites where direct services are provided. DFS staff is also housed at both sites of Child Development Watch and are fully incorporated into the multidisciplinary assessment team. In addition, DPH has collaborated with the Office of Child Care Licensing to improve the training and support for childcare providers in the areas of health and safety and in the development of the early childhood comprehensive systems planning. The Division of Child Mental Health has a working relationship with School-Based Health Centers, works closely with center coordinators to ensure appropriate referrals and obtain training for staff, and has contributed to the development of the Maternal and Child Health grant.

Federally Qualified Health Centers:
The Office of Primary Care is located in the Health Systems Management Section of DPH. The Health Systems Management Director assists as a facilitator to the Federally Qualified Health Centers and coordinates with the Family Health Section Director to ensure a variety of primary and preventive maternal and child health services.
The Office of Primary Care staff continue to work closely to ensure access to healthcare services for uninsured and underserved Delawareans. Delaware has benefited greatly from the President's Initiative to increase access to healthcare services through community health centers. Delaware now has two Federally Qualified Health Centers (FQHCs) in New Castle County (Henrietta Johnson

Medical Center), one in Kent County (Delmarva Rural Ministries/Kent Community Health Center), and one in Sussex County (La Red Health Services).

Perinatal Board: In November 1995, Governor Carper signed Executive Order Number 37 establishing the Delaware Perinatal Board. The Perinatal Board has over this past year disbanded while acting as an interim committee to assist with the preparation of legislation for a new Healthy Mother and Infant Consortium. The Consortium is the result of a major recommendation of the statewide comprehensive Infant Mortality Task Force. The final purpose of the Consortium with its goals and objectives are being finalized this summer.

March of Dimes:
The Family Health Services Director (Title V) had served on the Program Services Committee of the March of Dimes. The Family Health Services section staff voluntarily serves on various March of Dimes-Delaware Chapter (MOD) committees to improve the health of babies by preventing birth defects and infant mortality. There is current DPH representation on the Program Services, Grants Review and Community Outreach committees. These committees consist of representation from public and private agencies, business leaders, community advocates and family advisors. In 2004-2005, DPH also funded a statewide MOD community outreach environmental health initiative providing radon testing kits in the homes of pregnant women and families with infants. Delaware's MOD also is one of 15 chapters to support the NICU Family Support Program which provides direct service and support to families with infants in the NICU of Christiana Care Medical Center. Through our partnership, families are directly linked to DPH programs to assist with transition from hospital to home for the most vulnerable babies prior to discharge. The MOD staff collaborates and serves on DPH's Infant Mortality Task Force and the Fetal Mortality Review Committee.

The Perinatal Association: The Perinatal Association merged with Children and Families First; these partners share a similar mission. Children and Families First conducts counseling, foster care, and the Resource Mothers Program. There are nine (9) Resource Mothers, three (3) down state and six (6) upstate. Children and Families First will continue the tradition of targeting women least likely to seek services and the uninsured. PAD and DPH work as a team on shared client cases and work to provide each client with the most comprehensive care without duplication of activities.

Head Start and Early Childhood Assistance Program (EAP):Head Start is administered by seven community-based organizations throughout the state. Early Childhood Assistance Programs (ECAP) are state funded programs administered by the Department of Education and operated by seventeen community based organizations throughout the state, including existing Head Start grantees, school districts, and other early education agencies. The Division of Public Health participates on the Head Start State Collaboration project, which was established to develop state level partnerships for planning and policy development for Head Start eligible children and their families. The Head Start State Collaboration Office director serves on the Early Childhood Comprehensive Systems grant (ECCS) steering and executive committees and Healthy Child Care America-Delaware (HCCA-DE) advisory committee. Child Death Review Commission: The Child Death Review Commission was signed into Delaware law onThe Child Death Review Commission was signed into Delaware law on July 19, 1995. The Commission oversees the work of the two Child Death Review Panels, one for New Castle County and another for Kent and Sussex Counties. The Commission is composed of leaders from state agencies, police, nurses, physicians, attorney general's office, social workers, and child advocates. Its purpose is not to act as an arm of the police, but to look at systems to determine if the death was preventable. A death is considered preventable if one or more interventions might have averted it. The Commission legislation has been amended to now include child death, near death and stillborn. Efforts are in progress to establish a Fetal and Infant Death Review process in connection with the Child Death Review Commission.

The state is fortunate to have the involvement of its hospitals in not only ongoing and preventive care, but capacity building as well.

Christiana Care Health System, Inc.: Christiana Care Health System (CCHS) is the largest provider of

health care in the state. It has the only Level 3 neonatal intensive care unit (Christiana Care Special Care Nursery) in the state. The Division of Public Health collaborates with CCHS on many issues for instance; high-risk follow-up for premature infants is provided through a collaborative agreement between the hospitals and CDW. Christiana Care was the administrator for the Healthy Start project which lost its funding this year. However, the Division continues to work with CCHS to support the Healthy Start consortium. CCHS also contracts with DPH to administer several School-Based Health Centers. The CCHC's PMRI has been awarded a grant for the last three years by DPH for its Alliance for Adolescent Pregnancy Prevention program. Christiana Care also has representation on the Early Childhood Comprehensive Systems Steering Committee.

Bayhealth Medical Center: This center incorporates both Kent General in Dover and Milford Memorial Hospital in Sussex County. It is the second largest health care system in the state of Delaware. Bayhealth works on a variety of community initiatives such as the Central Delaware Community Health Partnership. Like Christiana Care, it also contracts with DPH to provide oversight for School-Based Health Centers. Bayhealth is also the lead for the Kent Prenatal Task Force, a group of representatives of public and private agencies who seek to improve systems of care in Kent County that impact on early entry into prenatal care.

DuPont Hospital for Children: The duPont Hospital for Children, located north of Wilmington, with funding from the Nemours Foundation, serves as a full-service regional pediatric medical center offering a complete range of clinical programs. It has established a system of pediatric clinics throughout the state to provide primary health care for unserved and underserved children. DuPont Pediatric Clinics provide check-ups; physicals; sick visits; vision, hearing, and lead screening; immunizations; referrals to specialists and a 24-hour medical advice hotline for parents.

Division of Health Prevention Services, Nemours Foundation: The Nemours Foundation established a Division of Health Prevention Services (HPS). The division focuses on child health promotion and disease prevention. The mission of the division is to improve children's health over time through an integrated community-base model that includes: Developing and implementing effective prevention programs, building on existing community resources, evaluating programs, while also contributing to the national landscape on children's health prevention research and providing business support services and technical assistance to non-profit and health related organizations. The Division of Public Health Title V has collaborated with HPS on their first three initiatives focused on diabetes, child mental health and obesity.

Nanticoke Memorial Hospital: Nanticoke Memorial Hospital had worked closely with Delaware Public Health to ensure early entry into prenatal care. A social worker and nutritionists had been housed at the Nanticoke Maternity Center so that they may refer eligible at-risk clients right into Smart Start. Nanticoke Maternity Center closed on 6/30/03. La Red Health Center has absorbed some of the prenatal patients who would have previously used the maternity center.

Beebe Hospital and Delmarva Rural Ministries: Beebe Hospital and Delmarva Rural Ministries have established a pilot program to provide medical care and links to social services for underserved populations of Sussex County through the MATCH van in targeted areas. Beebe Medical Center manages three School-Based Health Centers.

St. Francis Hospital: St. Francis Hospital is part of a nation-wide Catholic health system, located in the center of Wilmington. They are involved in community health outreach projects including health fairs and wellness days. They provide Tiny Steps, which is a comprehensive maternal fetal care program, which uses family physicians to provide prenatal, intrapartum, postpartum, and newborn care in Wilmington and Newark.

F. HEALTH SYSTEMS CAPACITY INDICATORS

Data and information are reported on Forms 17,18, and 19. A brief discussion of the indicators follows:

#01: The rate of children hospitalized for asthma (10,000 children less that five years of age). The asthma hospitalization rate has stayed relatively the same over the last three years.

#02: The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen. The percentage of Medicaid enrollees whose age is less then one year who received at least one initial periodic screen has fluctuated over the past four years. The fluctuation could possibly be contributed to the change in Medicaid MCOs twice during a four year period.

#03: The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen. All infants are eligible for Medicaid and therefore do not get SCHIP. For CY 2001 there were 5047 children under 1 receiving Medicaid; CY2002--5,425; CY2003---5,648; CY2004---5,857.

#04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index. The percent of women (15-44) for this indicator has remained generally the same over the last three data years.

#05: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State. The comparison has remained the same over the past years. The comparison is reflected in Form 18.

#06: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0-1), children, and pregnant women. The comparison is reflected in Form 18.

#07: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year. The percent of EPSDT eligible children aged 6 through 9 who have received dental services during the year has increased from 39.3 to 41.1. The maternal & child health program has coordinated efforts with the oral health program over the past three years, which may account for the increase. Greater entry of dental health services into the school system has been effective.

#08: The percent of State SSI beneficiaries less then 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program. 3,756 children less then 16 years of age are receiving services through the state CSHCN program .
#09-A: The ability of States to assure that the Maternal and Child Health Program and Title V agency have access to policy and program relevant information and data. The state through the SSDI grant is working towards linking data systems, especially when the electronic birth certificate is completed. A recommendation of the Infant Mortality Task Force has been to plan for conducting the Pregnancy Risk Assessment Monitoring System (PRAMS). This should increase the ability for MCH to access information and data.

#09-B: The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month. Delaware does not participate in PedsNSS.

#09-C: The ability of States to determine the percent of children who are obese or overweight. MCH does have access to WIC program data and YRBS data. The Division is cooperating with a new Division of Prevention Services through the Nemours Foundation. Their two major foci are currently child mental health and obesity in children. The MCH program will remain active with the Nemours Foundation in creating a strategic plan for the state to reduce childhood obesity, which includes gaining greater access to data and information related to the issue.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

Program activities are described and categorized by the four service levels found in the MCH "pyramid" -- direct health care, enabling, population-based, and infrastructure building services. Program activities as measured by the 18 National Performance Measures and the 10 state performance measures are depicted in the attached 0 graphic display.

B. STATE PRIORITIES

Title V or their match dollars are used to support many of the activities and thus the accomplishments related to both the national and state performance measures. While most of the dollars go to the county health units to provide direct and enabling services, some of the dollars are used to support infrastructure and capacity building and population based services in the central Title V office or those activities performed by the county units. As already described, it is difficult to separate Title V from other DPH initiatives, plans, and programs. Furthermore, it is equally hard to separate out a DPH role, for even when not taking a lead, DPH is usually an active participant.

The Division of Public Health and its collaborating agencies have a long history of supporting interventions that will help us to effectively meet our goals.

Based on the past needs assessment, below is the list of identified needs:
1. Ensure nutrition services to children and adolescents.
2. Improve dental health of children and adolescents.
3. Ensure medical home and coordinated services to children with special health needs.
4. Improve access to care in Kent and Sussex Counties and for black women throughout the state.
5. Reduce teen births.
6. Reduce preventable diseases in children and adolescents.
7. Reduce preventable injuries to children and adolescents.
8. Improve the mental health of children and adolescents through prevention and the assurance of appropriate treatment.
9. Reduce black infant mortality.
10. Reduce the barriers to delivery of care to pregnant women and women of child bearing years and reduce those risk factors resulting in infant mortality and congenital abnormalities in their infants.

These needs are addressed in a variety of programs throughout the state and served to help us to establish performance measures. The following brief summary outlines some of the needs assessment data, which lead the state to confirm its commitment to the above priorities.

Direct Services
Ensure nutrition services to children and adolescents. The latest YRBS showed there are a small number of adolescents that have severe nutritional problems such as bingeing and purging. On the other hand, over half are not eating vegetables on a regular basis or exercising. Although data was difficult to obtain, there do not seem to be enough nutritionists available to children in any consistent way and only to adolescents in a limited way through School-Based Health Centers. While children do learn about the basic food groups, this may be an academic exercise and not part of their lifestyle. The newly established Nemours Health and Prevention Services division is making obesity reduction a major initiative. Nemours is working with DPH and other major entities on the issue.

Improve dental health of children and adolescents. The lack of dental services for all poor Delawareans is self-evident. There is a severe shortage of dentists in Sussex County and a less than optimal situation in Kent County and in some sections of the city of Wilmington. Although Medicaid covers dental health for children, not enough dentists will take Medicaid patients. Those dentists that do take Medicaid can not keep up with the demand. The Delaware Healthy Children Program does not cover dental services but if it did, there would not be enough available dentists to provide

coverage. By the time, children come to the public health clinics; their teeth have too many cavities for sealants. When adolescents reach adulthood, dental services are even worse in that Medicaid does not pay for services for pregnant women.

Enabling Services
Ensure medical home and coordinated services to children with special health needs. It is clear from the ongoing needs assessment that coordination of services for CSHCN over three years is needed. Although there are numerous high quality services in Delaware, delivery is often fragmented and families and other providers are unaware of other services. In addition, a disconnection between education and medical providers has been noted.

Population Based Services
Improve access to care in Kent and Sussex Counties and for black women throughout the state. Access to care remains a problem in both Kent and Sussex counties and for black women throughout the state. Although Title V has decided to focus on care to all black women as a performance measure, we will continue to carefully review access in the southern part of the state where transportation and cultural barriers are significant. The widest disparity between the two races occurs in Sussex County. There are seven objectives related to access to health care services in Healthy Delaware 2010.

Reduce teen births. Although teen birth rates have dropped a little, our rate continues to be one of the highest in the nation. This is another area where there is a large racial disparity between the black teen birth rate and that for whites.

Reduce preventable diseases in children and adolescents. Asthma may not be very preventable but in some cases, it may be. For instance, roaches, smoking, and kerosene heaters are linked to childhood asthma. Although we do not have prevalence data, we have hospital discharge data, which shows that asthma is the number one cause of hospitalization for all children 1 to 9. This is also another area where a disparity between whites and blacks is very evident. Proportionately, black children have a higher rate of hospitalization for this disease. SIDS deaths had been decreasing but have recently started to rise again. Although not all are preventable, putting the baby on the back and not using overstuffed blankets can prevent many SIDS deaths. Finally, the state continues to be concerned that children are not getting lead screens, as they should. This problem is particularly noticeable in examining Medicaid data. These are some of the most vulnerable children in the state often living in older homes where lead may be a problem.

Reduce preventable injuries to children and adolescents. The leading cause of death for children 1 to 14 years in the state of Delaware is unintentional injuries. Motor vehicle crashes are the number one leading cause of unintentional injury death in 1-19 year olds. YRBS data also show that the majority of high school students do not always wear a seat belt. Poisoning and toxic effects of drugs are the seventh (7th) most prevalent reason for hospitalizations for children ages one to four years. Although safety seat use and seat belts have increased, many drivers do not know how to adjust them correctly. Alcohol use by adolescents remains a serious problem. YRBS data shows that almost one half of all students drink. Alcohol use is directly related to injuries to adolescents particularly in motor vehicle accidents but in other injuries as well.

Infrastructure Building
Reduce black infant mortality. The disparity between the rates of black infant deaths and white infant deaths has remained about the same for the last ten years. The state's City Match Data Institute team has identified extremely low birth weight and prematurity as the chief direct causes. The state is also considering stress and racism as factors that underlie the problem since both Delaware and national data show that educated black women and those that have accessed care early are still in more danger of losing their infants than white women.

Reduce the barriers to delivery of care to pregnant women and women of child bearing years and reduce those risk factors resulting in infant mortality and congenital abnormalities in their infants.

Reducing the barriers has been identified has a high priority to delivery of care. Identified barriers include access to care problems such as cultural, transportation, and insurance issues. Risk factors include lack of early care, substance abuse including tobacco use, lack of good nutrition, being unmarried, giving birth again after less than an 18-month interval, and the age of the mother. There are seven objectives related to Infant health in Healthy Delaware 2010.

Improve the mental health of children and adolescents through prevention and the assurance of appropriate treatment. Mental health issues were raised in many venues: in preparation for the Rural Health Plan, by the Developmental Disabilities Planning Council, by parents in SBHC focus groups, and in review of SBHC data, DCMH client visit, YRBS data, and hospital discharges. After the age of ten, mental health problems were one of the chief causes for hospitalization for white children. While early intervention and prevention have been noted as crucial, there is clearly a gap in providers particularly in southern Delaware. Lack of insurance coverage has been raised as a problem. The Division of Child Mental Health supports services to children who are on Medicaid or uninsured, which does not include the underinsured.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				100	100
Annual Indicator			100.0	100.0	100.0
Numerator			11083	11337	11337
Denominator			11083	11337	11337
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

The number actually screened is 11,679. The total occurrent births is 11,679. The percentage is 102.8%. (TVIS system would not allow for percentages of over 100%.) The additional screens result when adopted babies receive screens in Delaware but were born elsewhere.

a. Last Year's Accomplishments

Enabling Services

The State of Delaware Guideline for the Management of Sickle Cell Disease was implemented. This guideline is a tool that assists primary care practitioners in the management of Sickle Cell Disease for patients from birth until the end of life. Children birth to three with sickle cell are eligible for Delaware's Part C Program, Child Development Watch, and receive comprehensive service coordination for those families who agree to participate in the program. Others are

assisted through the Kids Kare program.

Population-Based Services
The state continues to screen for Phenylketonuria (PKU), Congenital Hypothyroidism (CH), Galactosemia, Congenital Adrenal Hyperplasia (CAH), and Hemoglobinopathies.

Expanded newborn screening has been implemented and infants are now screened for approximately 31 disorders. Because of ethical considerations, only those problems that can be treated are screened for. Expanded newborn screening has been implemented for Maple Syrup Urine Disease (MSUD), Homocystinuria,Hyperphenylalinemia, Other Amino Acid Disorders, Glutaric Aciduria Type I, Organic Acid Disorders, Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCAD), and Fatty Acid Disorders.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expanded newborn screening has been implemented for Homocystinuria, MSUD, Tyrosinemia, Urea Cycle disorders, other aminoacidopathies, MCAD, other Fatty acid oxidation, Methylamalonic academia, Proprionic academia, Isovaleric academia, Glutaric acidur			X	X
2. Repeat PKU Tests are done upon request.		X	X	
3. Home Visiting Program for first time parents follows up for Newborn Screening for 2nd flood draws and calls Medical Office to notify, if needed. HVP provides linkage in situations where failure to get 2nd draw.	X	X		
4. Home Visiting Program works collaboratively with Newborn Screening to ensure follow-up on medical testing for children with genetic disorders.	X	X		
5. Counseling and follow-up with families are provided.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Enabling Services
The Specialty Formula Fund is funded with state dollars in order to pay for specialty formula, prescribed by a provider, for inherited metabolic disorders not covered by insurance companies. In 1996, this fund was established and regulations developed to cover the cost of specialty formula for under and uninsured citizens based on a sliding fee scale and on household income. Due to the lack of funding requests for specialty formula, the committee, which manages this fund, recommends regulation revisions governing the use of the fund resources. The committee recommends the following:

• The funds be maintained at current level,
• The funds should also include specialty formula and food for any Delawarean diagnosed with an Inherited Metabolic Disorder.
• Rebate assistance be provided for required specialty formula and food for those families who apply
• The excess funds be made available to offer one to three scholarships to children with PKU or

other metabolic disorders to attend specialty educational camp where they will have the opportunity to learn more about their disorder, diet, treatment options and also learn from their peers.
• Additional excess funds should also be available to provide necessary specialty diet educational materials, including gram scales for the specialty formula and food.

Population Based
DPH county field staff continues to support the screening program by providing follow-up in the home when screenings have not occurred in the hospital,(i.e., home births or initial screens missed at discharge from the hospitals) or when a repeat screen is needed. While most repeat screens are completed at the hospital, a referral is made to Public Health Nursing for home visits when the family of an infant with an abnormal newborn screening result is not responsive to follow-up visits.

c. Plan for the Coming Year

Enabling
The Specialty Formula Fund Committee will continue to track potential revisions to the regulations governing the fund to provide necessary specialty formula and foods to Delawareans. The Committee will meet quarterly. The fourth draft of the new regulations includes reimbursement for specialty foods, education materials, medical supplies, and educational camps for the children and their families.

Population Based
DPH county field staff will continue to support the newborn screening program by providing follow-up in the home when screenings have not occurred in the hospital ,(i.e., home births or initial screens missed at discharge from the hospitals) or a repeat screen is needed. While most repeat screens are completed in the hospital, a referral is made to Public Health Nursing for a home visit if an infant with an abnormal newborn screening result cannot be located.

The state will continue to screen for Phenylketonuria (PKU);Congenital Hypothyroidism (CH);Galactosemia, Congenital Adrenal Hyperplasia (CAH), and Hemoglobinopathies.

Expanded newborn screening has been implemented and infants are now screened for approximately 31 disorders. Because of ethical considerations, only those problems that can be treated are screened for. Expanded newborn screening has been implemented for Maple Syrup Urine Disease (MSUD), Homocystinuria,Hyperphenylalinemia, Other Amino Acid Disorders, Glutaric Aciduria Type I, Organic Acid Disorders, Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCAD), and Fatty Acid Disorders. The state is currently working on plans to include newborn screening for Cystic Fibrosis and Biotinidase Deficiency to the screening panel. The state will continue to work with its Newborn Screening Advisory Committee to investigate additional disorders to add to the current screening panel.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective				60	60
Annual Indicator			56.9	56.9	56.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	65	65	65	65

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Enabling

Child Development Watch continued to engage the family in each step of the process for reviewing program and policy. The family orientation was specifically focused on the natural environment of the client. Families were encouraged to participate in standards review and development, monitoring of Individualized Family Service Plans (IFSPs), and monthly forums. The forums were advertised more widely, which increased attendance.

The Delawareans with Special Health Care Needs Medicaid Managed Care Panel met monthly with a consistent attendance of parents and their children attending. The panel held alternate monthly meetings upstate and downstate with alternate times either late afternoon or evening. The variety of times accommodated families and encouraged participation.

Infrastructure Building

Involvement of parents continued as a priority for the past year. The CSHCN Office engaged the Coordinating Council for Children with disAbilities (CCCD), a private not-for-profit corporation, to enhance the participation of families. Discussions were held to enroll interested parents into the process. One problem that Delaware faced in the involvement of parents was the inability to offer a stipend. Since funds were limited, it was unlikely that the state would hire a family member consultant or provide financial support for parent activities.

However, several initiatives encouraged parent participation. The Child Development Watch program continued Spanish-speaking support groups where families met monthly to network and receive relevant information related to their CSHCN. Conferences made available enhanced parent participation. These included "Faith Communities and Building Healthy Communities", and "Grandparents and Relative Caregivers Program". Similar programs are scheduled for the future.

Another opportunity for parent participation was with the Delawareans with Special Needs/Medicaid Managed Care Panel. Representatives of the State's Medicaid Office, the

Director of Children with Special Health Care Needs, and the Managed Care Organizations (MCO) met monthly to discuss health care insurance issues presented by parents of CSHCN. The parents' issues were reviewed at the meeting, minutes were taken, and the resolutions to the problems were discussed at the following meetings. The Medicaid and MCO representatives were very cooperative in addressing all issues in a timely manner. In addition to meeting needs, the focus encompassed anticipatory mental and physical needs for CSHCN and the family.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Development Watch includes the family in standards development, monitoring plans and Individualized Family Service Plans.				X
2. Partners in Policy Making include advocacy training in the family's training.			X	X
3. The Delawareans with Special Health Care Needs Managed Care Panel meets monthly and responds to families' needs.		X	X	
4. The Interagency Coordinating Council and The coordinating Council for Children with Disabilities include amilies in decision-making and program assessment.		X	X	
5. The Division of Public Health conducts Family Survey annually.			X	X
6. The Division of Public Health encourages family participation in focus groups as needed.			X	X
7. Family members attend regular clinical meetings.		X		
8. Child Development Watch "New Scripts" parent group actively participate in a number of committees to improve care of disabled children and their families. Most recently they are participating in the First Signs program and are providing input to the		X		X
9.				
10.				

b. Current Activities

Enabling
Child Development Watch continues to involve the family in their process. Families remain active in monitoring standards review and development. They also participate in the development and monitoring of Individualized Family Service Plans (IFSPs). The monthly forums are held with special topics of family interest to be presented.

The Delawareans with Special Health Care Needs Medicaid Managed Care Panel continues to meet monthly. A videoconference link between two sites, one upstate, and one downstate increases communication and participation among families.

A Coaching and Counseling initiative atarted in a statewide effort to improve services through the early intervention system. Formal training started in January,2005 with a follow up in August. A Steering Committee has been established to continue the process.

The results of the National Survey of Children with Special Health Care Needs with a focus on family participation was reviewed by the Coordinating Council for Children with Disabilities. The Family Voices representative encouraged other family members to participate on the Council.

Infrastructure Building
The Coordinating Council for Children with disAbilities continued to be a forum for family participation in policy planning and development. The Director of CSHCN provides staffing responsibilities to the Council with an outstanding partnership with the A.I.duPont Hospital for Children.

c. Plan for the Coming Year

Enabling
Child Development Watch will continue to involve the family in their process at every level possible. Families will continue to be supported to participate in standards review and development and in the development and monitoring of IFSPs. The monthly forums will continue with special topics of family interest to be presented.

The Delawareans with special Health Care Needs Medicaid Managed Care Panel will continue to meet monthly with videoconference links between two sites, one upstate, and one downstate.

A Family Survey Report will be conducted by the University of Delaware. The topics will focus on a discussion with families regarding their experiences with Child Development Watch including awareness of CDW; assessment and evaluation; coordination of services; interactions with service coordinator; delivery of services; family support; and transition from Part C.

A Coaching and Counseling Steering Committee will continue to asess the progress of the initiative.

The results of the Family Survey Report conducted by the University of Delaware will be reviewed and analyzed with possible changes made relating to the issue of family participation.

Infrastructure
The Coordinating Council for Children with Disabilities will continue to be a forum for family participation in policy planning and development. The Director of Family Health Services will staff the Council.

The needs assessment will be shared with both the Coordinating Council and the Interagency Coordinating Council for Part C, which include parents as members. The Chair of the ICC is also the state coordinator of Family Voices in Delaware. The Family Voices Coordinator is also a parent representative and has been quite active with the Children with Special Health Care Needs (CSHCN) program. The CSHCN office will continue to provide financial support for Family Voices mailings.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective				55	55
Annual Indicator			52.8	52.8	52.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55	60	60	60	60

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Enabling

Child Development Watch continued to include each child's primary care physician as a member of the CDW multidisciplinary assessment team. Four thousand, eight hundred, twelve 4,812 referrals for children ages from birth to twenty-one (0-21). Over 1,300 children, ages 0-3 were assessed for eligibility under Part C. All of these children and families were linked to a medical home, if one had not been established. This function remains the responsibility of the CDW Service Coordinator. Children receiving Kids Kare were also linked to a medical home.

Infrastructure Building

DPH continued work ensuring medical homes for all children. The Delaware Healthy Children program and the outreach program funded through a Robert Wood Johnson Foundation grant helped to insure all children and provide them access to a medical home. The Office of Children with Special Health Care Needs in DPH has continued to work with the Delaware Chapter of the American Academy of Pediatricians in the development of the medical home project as that committee merged with the Medical Home Subcommittee of the Early Childhood Comprehensive project. The merged committee created an action plan for the medical home initiative.

The Special Needs Alert Program (SNAP) enrolled its first families. A coordinator was hired through a subcontract with Easter Seals. The program involved a ‘flagging' of the CSHCN during a 911 call and included training and education components connecting the CSHCN and their families to medical homes. A website was created as an interactive resource and is hosted by the chair of the workgroup. The program was officially named Special Needs Alert Program (SNAP). The SNAP project is conducting a pilot project with selected families through the A.I.duPont Clinics located throughout the state. Once the pilot project is system tested, a fully implemented SNAP will be established, along with the appropriate education, training and marketing for the program.

Delaware investigated the needs of children with traumatic brain injury. Lack of follow-up after

hospital and emergency room discharge was noted. Ongoing discussions during the year resulted in a major change in strategic planning to address traumatic brain injury and acquired brain injuryTBI/ABI. A new subcommittee of the State Council for Persons with Disabilities was formed with a mission statement to "improve the lives of Delawareans with brain injury by providing: 1.) A forum for sharing and analysis of information; 2.) A network to identify and facilitate acquisition of enhanced resources; 3.) A technical assistance provider to educate public and private policy makers; and 4.) An advocacy agency to promote consumer oriented effective injury prevention and service delivery systems." The twenty-member Brain Injury Committee (BIC) included four persons with TBI. The Director of CSHCN has been one of the key people in the development of the BIC to raise the TBI/ABI to a new level in the state

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Development Watch includes the child's primary care physician as a member of the multidisciplinary assessment team.		X		
2. Children in the Kids Care program are connected to a medical home and primary care physician.		X		
3. The Medical Home Subcommittee of ECCS meets monthly to implement the medical home concent.			X	X
4. The Division of Public Health provides information, assistance with application and/or referral.		X		
5. Division of Public Health support staff addresses issues concerning the Hispanic population by taking classes in cultural diversity and effective communications with limited English speaking populations. DPH has arranged weekly Spanish classes for i				X
6. Physical assessment by developmental pediatrician provided to each child as part of initial evaluation. Consultation with child's PCP as needed by developmental physician.	X	X		
7. The Special Needs Alert Program was established to develop a system by which children with special care needs could be linked to community emergency personnel. This link would allow families with children who have medical needs to provide the 911 st		X	X	X
8. Delaware is participating in the First Signs Program which is designed to provide education and a method of early screening for developmental delays that is adaptable to pediatric practices in the state.			X	X
9.				
10.				

b. Current Activities

Enabling
The Child Development Watch Service Coordinators maintain the function of linking the children to a medical home and including the physician as part of the multidisciplinary assessment team, especially through the IFSP process with the family. The ISIS computer based system tracks the number of children served and the number of children linked to a medical home. Kids Kare also continues to link children and their families to medical homes. Discussions continue on the possible expansion and enhancement of the Kids Kare program beyond the zero through age six current priority of the program. This will allow further enhancement of the medical home concept to include all at-risk children ages 0-21. Five

thousand, three hundred, ninety-two (5,392) referrals for children ages from birth to twenty-one (0-21) were received through the central intake system. Over 1,360 children, ages 0-3 were assessed for eligibility under Part C. All of these children were linked to a medical home.

Infrastructure Building

The Division of Public Health continues to support a medical home for all children. The merged Medical Home Subcommittee continues to work on the action plan and addressed methods of implementation of portions of the plan. Collaboration continues with the Medical Society of Delaware who received a Robert Wood Johnson grant, which includes objectives related to medical home.

The SNAP project continues to enroll families through the A.I.duPont Clinics located throughout the state. Appropriate education, training and marketing for the program is occurring with the main assistance of the Office of Emergency Medical Assistance for Children. SNAP was highlighted at a recent statewide conference on emergency preparedness.

The Brain Injury Committee has been meeting monthly throughout the year to address the issues of TBI/ABI. Linking those children with TBI/ABI with medical homes is part of the agenda for the BIC. A legislative amendment was approved to address the inclusion of a TBI category within the Department of Education so that children with TBI will better be able to be tracked, as well as to receive the appropriate special services within the school system. The BIC as part of the Governor's appointed State Council for Persons with Disabilities remains an advocate to CSHCN with TBI/ABI for links to appropriate and effective medical homes.

c. Plan for the Coming Year

Enabling
The Child Development Watch Service Coordinators will continue to maintain the function of linking the children to a medical home and to include the physician as part of the multidisciplinary assessment team, especially through the IFSP process with the family. The ISIS computer based system will track the number of children served and the number of children linked to a medical home. Kids Kare will also continue to link children and their families to medical homes. Discussion will continue, regarding the possible expansion and enhancement of the Kids Kare program beyond zero (0) through age six (6), which is the current priority of the program. This will allow further enhancement of the medical home concept to include all at-risk children ages zero through twenty-one (0-21).

Infrastructure Building
The Division of Public Health will continue to ensure a medical home for all children. Further collaboration is planned with the Medical Society of Delaware, who received a Robert Wood Johnson grant that includes objectives related to medical home. The merged Medical Home Subcommittee will implement the action plan given available funds.

SNAP will continue to enroll families through existing health care systems, including those responsible for home visiting. The project will also link with the emergency preparedness planning efforts throughout the state

The Brain Injury Committee (BIC) will continue to meet monthly throughout the year to address the issues of traumatic brain injury (TBI) and acquired brain injury (ABI). Linking those children with TBI/ABI with medical homes will continue to be a part of the agenda for the BIC. The BIC as part of the Governor's appointed State Council for Person with Disabilities will remain an advocate to CSHCN, with TBI/ABI for links to appropriate and effective medical homes. In addition the Injury Prevention Coalition has revived a TBI/Spinal Cord Committee to address those issues from a prevention perspective. The Director of CSHCN is an active member of

that committee.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				67	67
Annual Indicator			66.7	66.7	66.7
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	67	70	70	70	70

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Enabling
According to the Kids Count report, 15,702 applications for the Delaware Healthy Children Program (DHCP) were mailed to families through November 2003. The total children currently enrolled are four thousand eight hundred sixty-eight (4,868). There remains the close link between the DHCP and Medicaid as children transition between the two programs when family incomes fluctuate.

Delaware took steps towards working with the immigrant populations around the issue of child health coverage; many immigrants fear that applying for health insurance for their children could affect their immigration status. Application forms for both Medicaid and DHCP were revised to contain a statement that alien verification information did not affect immigration status or lead to deportation.

Referrals were made to the A.I. duPont Pediatric Clinics when a child did not have insurance or

a medical home. In addition, all DPH programs, such as CDW, Kids Kare, immunizations etc., worked to ensure that children, under their care, were referred to Medicaid when it was determined that they do not have a source of insurance. Child Development Watch also ensured that Part C dollars are available for early intervention services when there was no source of insurance. DPH staff will also refer and help with applications to private insurance where applicable.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Development Watch staff has been instrumental in helping children enroll in Medicaid, and Delaware Healthy Children's Program.		X		
2. Kids Count is gathering data annually and tracking the percentage of children with insurance.				X
3. Referrals are made to A. I. DuPont pediatric clinics when a child does not have insurance.		X		
4. Contract doctors provide services for under and uninsured to age 21; Pediatric Neurology and Pediatric Cardiology, Pediatric Ophthalmology provided for Medicaid, under insured and uninsured in partnership with DVI.	X	X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct Services
The Division of Public Health continues offers diagnostic and short-term treatment services for children with special needs in Kent and Sussex Counties where geographic and health access is limited. These services continue to include cardiac, genetics, neurology and ophthalmology. DPH participates on the Cleft Palate/Oral Facial Clinical Team in conjunction with the A.I.duPont Hospital for Children. The genetic service includes genetic counseling for the families in Southern Delaware. A pediatric neurologist continues to provide services in Kent and Sussex Counties.

The Preschool Diagnostic Developmental Nursery provides early intervention services to the birth to three populations with a multidisciplinary approach and with the appropriate services.

Enabling Services
The Division of Public Health continues the operational responsibility for the Part C Birth to Three program under Child Development Watch (CDW).

The DPH provides services for at-risk children through the Kids Kare Program. Discussions continue on the possibility of expanding and enhancing the Kids Kare Program beyond the current priority to serve the birth to six years of age population in Delaware. Title V supports

positions that are responsible to provide the assessment and case management services under the auspices of Kids Kare as well as program administration. In the most rural Southern Delaware, the Amish Community is assisted by the team of public health nursing and social work to provide resources for special care needs. An evaluation of the Kids Kare program is underway with a final report due in the fall of 2005.

Referrals are submitted to the duPont Pediatric Clinics when a child does not have insurance or a medical home. In addition, referrals to Medicaid and the Delaware Healthy Children Program are made by all DPH programs (CDW, Kids Kare, immunizations etc.) when it is determined that the children under their care lack insurance or are underinsured. Child Development Watch also ensures that Part C dollars are available for early intervention services when there is no source of insurance. DPH staff also refers and help families with applications to private insurance when applicable.

c. Plan for the Coming Year

Direct Services
The Division of Public Health will continue to offer diagnostic and short term treatment services for children with special needs in Kent and Sussex Counties where geographic and health access are limited. These services will include cardiac, genetics, and ophthalmology. DPH will also continue to participate on the Cleft Palate/Oral Facial Clinical Team in conjunction with the A.I.duPont Hospital for Children. The genetic services will include genetic counseling for the families in Southern Delaware. A pediatric neurologist will continue to provide services in Kent and Sussex Counties.

The Preschool Diagnostic Developmental Nursery will continue to provide early intervention services to the birth to three populations with a multidisciplinary approach and with the appropriate services.

Enabling Services
The Division of Public Health will continue the operational responsibility for the Part C Birth to Three programs under Child Development Watch (CDW).

The DPH will provide services for at-risk children through the Kids Kare program. Title V will support positions that are responsible to provide the assessment and case management services under the auspices of Kids Kare as well as program administration. In the most rural Southern Delaware, the Amish community will be assisted by the team of public health nursing and social work to provide resources for special care needs.

Referrals will continue to the A.I.duPont Pediatrics Clinics when a child does not have insurance or a medical home. In addition, all DPH programs (e.g. CDW, Kids Kare, immunizations etc.) will work to ensure that children under their care are referred to Medicaid when it is determined that they do not have a source of insurance. Child Development Watch will also ensure that Part C dollars are available for early intervention services when there is no source of insurance. DPH staff will refer and help with applications to private insurance where applicable.

The recently released "Kids Count in Delaware Fact Book; 2005" will be reviewed and analyzed.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				75	75
Annual Indicator			72	72	72
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	80	80	80	80

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Enabling

The Medical Home Subcommittee of the Early Childhood Comprehensive Program met monthly to establish and maintain at the community level the development of the medical home system. An action plan was developed which included discussion of easily accessible community based services. Several pediatric practices met biweekly to enhance their medical homes for CSHCN.

Infrastructure

Four major councils within the state that addressed: needs assessment, policy development, and systems of care. The Interagency Coordinating Council (ICC) continued to build awareness among a variety of public and private institutional representatives. The Director of CSHCN maintained a standing agenda item for the quarterly meetings that focused on system coordination. The MCH Director remained the Division of Public Health's appointed representative on the ICC.

The State Council for Persons with Disabilities also addressed coordination of efforts for the population. One of its subcommittees focused solely on Traumatic Brain Injury. This involved policy development and research for preparation of legislation. The MCH Director remained the appointed representative on this state council, with the Director of CSHCN as an active member of the brain injury committee.

The Governor's Advisory Council for Exceptional Citizens (GACEC) addressed the coordination of efforts for the children receiving special education in the school system. The Policy and

Legislative Committee addressed the development of systems of care and services for the children and their families. The Director of CSHCN remained the appointed representative on the GACEC.

The Coordinating Council for Children with Disabilities (CCCD) met monthly to address a major statewide needs assessment for the birth to 21 CSHCN populations. The Council continued to build the capacities of the public and private agencies that faithfully attended the meetings. The CCCD has worked with CompCare for technical assistance on both a survey of agencies serving CSHCN in the state, and on Focus Groups in the community for the purpose of assessment of services and the ease of service access by the families.

The Developmental Disabilities Council also addressed coordination, policy development and needs assessment for persons with disabilities across the lifespan. The Council worked to increase the capacity of agencies in the development of community based systems of services. Small grants were offered to conduct trainings, to establish pilot projects, and to research coordination of transportation needs.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A Family Survey Report under Early Intervention is finalized and will be reviewing the data on family satisfaction.				X
2. Four major statewide councils address the organization of service systems that include CSHCN.			X	X
3. DPH provides care coordination through Kids Kare.		X		
4. All children referred to program before eligibility for Part C is determined. Care coordination transferred to DPH or PCP at conclusion of eligibility, or ineligibility.		X		
5. CDC NCC has a monthly group for Hispanic families to provide education and socialization for children.		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Enabling

The Medical Home Subcommittee of the Early Childhood Comprehensive Systems Committee (ECCS) meets monthly and has created a draft action plan. The Medicaid office is a part of the planning process in addition to the Delaware AAP, Family Voices, Child Development Watch, A.I.duPont Hospital for Children, and the CSHCN program.

Infrastructure

Representation on the four councils continues. The ICC is reviewing and commenting on the IDEA reauthorization, along with the Governor's Advisory Council for Exceptional Citizens.

The results of the National Survey of Children with Special Health Care Needs were shared with agencies and families as part of the ongoing needs assessment process.

c. Plan for the Coming Year

Enabling
The Medical Home Subcommittee will continue to meet as part of the Early Childhood Comprehensive Systems program. The committee will be implementing the action plan given available funding.The co-chairs are Dr. Linda Cabellero of A.I.duPont and Dennis Rubino, Director of Children with Special Health Care Needs. The Medicaid office will continue to be a part of the planning process in addition to the Delaware AAP, Family Voices, Child Development Watch, and A.I.duPont Hospital for Children, and families

Infrastructure
Representation on the four councils will continue. The ICC will be reviewing and commenting on the IDEA reauthorization, along with the Governor's Advisory Council for Exceptional Citizens. The Coordinating Council for Children with Disabilities will follow up on the results of the CompCare report when received.

The Family Survey Report completed by the University of Delaware will be analyzed and shared with agencies and families.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				20	20
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	20	25	25	25

Notes - 2002
Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Enabling
The topic of transition had been in the forefront recently through a major iniative undertaken by the A.I.duPont Hospital for Children. The Transition Subcommittee of the executive committee met monthly to focus on transition systems issues. The committte invited the Institute of CHild Health Policy to present at grand rounds at two major hospitals and to a seperate stakeholder group. The CSHCN Director was an active member of the committee. A Champions for Progress grant was submitted on the issue of transition of young adults to adult health and social services but was not approved.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Transition Committee meets monthly to assess transition needs and to develop a transition plan.		X		X
2. The Coordinating Council for Children with Disabilities is addressing the transition issue.				X
3. A survey of children who have 'graduated' from A. I. DuPont Hospital for Children is being planned to assess transition needs in the community.				X
4. Delaware participates in the General Supervision and Enhancement Grant which has been devised to provide an accountability system for Part C (CDW) and Part B (school system)>				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Enabling
A plan to address transition issues is drafted and is to be presented to the executive committee of the A.I.duPont Hospital for Children. The Transition Committee continues to meet monthly under the leadership of the A.I.duPont Hospital for Children. A survey is being planned for those clients of A.I.duPont Hospital and clinics who have ‘graduated' from their services. The hospital serves CSHCN through age 18. During this cycle, a second version of a Champions for Progress grant was submitted on the topic of transition.

c. Plan for the Coming Year

Enabling
The Transition Committee meets monthly under the leadership of the A.I.duPont Hospital for Children. Approximately 500 young adults are discharged at age 18 to adult health and social services. (A.I. DuPont Hospital is the major provider of services to CSHCN in Delaware.) The committee will support the plan as described in the Champions for Progress grant with a focus on the issue of transition of CSHCN to adult health and social services.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	87	90	90	90	90
Annual Indicator	82.9	78.1	80.2	80.3	82.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2002

This data comes from the CDC National Immunization Survey and is not available at this time. We will provide when it is available.

Notes - 2003

The data for 2004is not yet available. It comes from the National Immunization Survey and will be available next year at this time.
Current dat is for the fiscal yaer of Jul1 through June 30.

Notes - 2004

2004 data is not available as yet.

a. Last Year's Accomplishments

Direct Services All children were screened for immunizations if they had visited a DPH Well Child or WIC clinic.

DPH provided additional attention to the Amish community in Kent County. Many Amish children are not immunized despite ongoing efforts to increase rates in the Amish community. There was an outbreak of Pertussis beginning in October 2004. Efforts to contain the outbreak were met with outstanding cooperation from the Amish community. Additional immunization and treatment clinics were setup in the Amish community. Exposure control efforts worked well and aided in the control of Pertussis. Only a few non-Amish children and adults were reported as being affected.

Enabling Services
Southern Health Services continued to contract with Delmarva Rural Ministries for the mobile treatment health van, or MATCH van.
Population Based Services

School nurses helped assure immunization compliance of all children transferring or entering school for the first time. The program conducted a "Lot Quality" Assurance Assessment (LQA) at the six (6) birthing hospitals in Delaware. The assessment gathered information regarding the screening for hepatitis B in pregnant women during their pregnancy and the percent of infants receiving the birth dose of hepatitis B vaccine before leaving the hospital.
Infrastructure
Delaware's Immunization Program made significant progress over the course of the past year at developing infrastructure, implementing more responsive monitoring, and evaluative processes, and establishing a far-reaching marketing program.

The only significant change in the number of vaccines offered under the program has been the introduction of meningococcal conjugate (Menactra).

The program has instituted greater scrutiny of vaccine distribution and usage to insure that program providers appropriately use supplies. This scrutiny was evident in a number of activities including greater oversight of VFC vaccine distribution, more intense analysis of the State Immunization Registry to verify the proper use and reporting of vaccines and increased number of AFIX/VFC site audits. The program has achieved a less than 5% vaccine wastage rate.

The program maintains an immunization registry and has made the registry available to providers, school nurses, day care providers, etc via the World Wide Web. State regulations require providers to report all immunizations given to the registry.

The program completed a marketing plan. The purpose of which was to establish marketing strategies that includes providers and consumers that can impact the immunization coverage in Delaware.

Partnerships with the Delaware Department of Education, the Delaware Office of Child Care Licensing, the Delaware WIC program, the Delaware adult Flu Coalition and the Delaware Valley Immunization Coalition continued. In each of these instances, to better monitor and improve immunization rates among populations, we enhanced cooperative activities.
Delaware's policy for

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Intense analysis of the State Immunization Registry to verify the proper use and reporting of vaccines and increased number of AFIX/VFC site audits is ongoing.				X
2. Partnership with the Delaware Department of Education, the Delaware Office of Child Care Licensing, the Delaware WIC program, the Delaware Adult Flu Coalition and the Delaware Valley Immunization Coalition to enhance our cooperative activities to bet				X
3. Northern and Southern Health Services provide immunizations in their well-child clinics, primarily for uninsured children. DPH will continue to monitor and provide services to the Amish population.	X		X	
4. The Immunization Program is working on a link to the newborn screening registry.				X
5. The Immunization Program is planning marketing initiatives as a result of the marketing survey.			X	X

6. Flu immunization clinics are held throughout the fall to ensure that children received the flu shot.	**X**	**X**		
7. Nursing staff provides physical assessments and immunizations to clients eligible for services under the Division of Public Health. For those not eligible for our service we also provide information, referral and education on the importance of immun				
8. NHS provided public health influenza (flu) clinics in November and December 2004 and January 2005 targeting the CDC designated high risk populations of infants from 6 months to 23 months.	**X**			
9.				
10.				

b. Current Activities

Direct Services
Northern and Southern Health Services provide immunizations in their well-child clinics, primarily for uninsured children. DPH continues to monitor and provide services to the Amish population.

Population Based:
School nurses track immunizations for children entering school for the first time. Feedback regarding the results of the LQA survey are scheduled for the Delaware birthing hospitals.

Infrastructure Building:
The Immunization Program is tracking the introduction of Menactra to determine the usage and impact on availability of the vaccine.

One goal that has not been met is to fully populate the State Immunization Registry with all of Delawarean children's vaccinations. The Immunization Program and New Born Screen program are implementing an electronic linkage between the two registries, which will ensure that all children born in Delaware are automatically enrolled in the immunization registry.

The program is currently working on the process of web enabled data entry process for providers and school nurses. Once completed, it will be much simpler and quicker for information to be provided to the registry

c. Plan for the Coming Year

Direct Services
Northern and Southern Health Services will continue to provide immunizations in their well-child clinics, primarily for uninsured children and immunization record review at WIC clinic. DPH will continue to monitor and provide services to the Amish population.

Population Based
School nurses will continue to track immunizations for children entering school for the first time while using the Delaware Immunization Registry via the World Wide Web.

Infrastructure Building
The Immunization program will continue to contract with an outside agency to AFIX audit private physician practices in New Castle, Kent, and Sussex counties to determine the immunization status of their pediatric clients.

AFIX is an immunization audit tool. The process will provide a realistic assessment of coverage, identify barriers, allow for the exchange of ideas and support in developing solutions, and provide incentives.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	38.2	37.7	37.2	30	29
Annual Indicator	34.4	31.5	29.7	34.1	34.1
Numerator	2571	2399	2316	387	387
Denominator	74808	76266	77911	11337	11337
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	28	27	26	26	26

Notes - 2002

Because of our small numbers, he rate represented is the five- year running average rate. We do not have vital statistics data yet for 2002. That information will be released next year.

Notes - 2003

2003 data is not available.

a. Last Year's Accomplishments

Direct Services
State funding provided additional social work hours for intensive one-on-one counseling to identify "at-risk" teens based on the "Tran theoretical Behavior Change Model" (TTM) at six School-Based Health Centers (SBHCs).

The state continued contracts with the Liberty Court Boys and Girls Clubs in Kent County to provide structured after school activities covering a variety of topics such as self-esteem and peer pressure.

A contract for teen pregnancy prevention services at the Claymont Community Center iprovided counseling/social work services and a variety of group activities to provide after-school and summer programming including educational group sessions on teen pregnancy prevention, STD/HIV, adolescent health, self-esteem, decision-making skills and goal setting, mentoring, individual counseling, and educational/cultural activities.

"Wise Guys" was an adolescent male responsibility program that used an established "Wise Guys" curriculum over a ten-week period. The program promoted character development and prevention of adolescent pregnancy by teaching young males self-responsibility in several areas. The program was offered in nine high schools. (Howard, Woodbridge, Seaford, Sussex Central, Brandywine, Milford, Smyrna, Indian River and Cape Henlopen).

Abstinence education was provided at four sites of the Boys and Girls Club of Delaware using the "A.C. Green's Game Plan Abstinence Program". The Family Advocacy and Research Council provided abstinence programming for teen girls using the " Moral Resonation Therapy" model.

DPH and private agencies provided reproductive health services, some of which were specifically aimed at teens during teen specific periods. Thirty-five percent (35%) of all clients were teenagers. In 2004, 7,273 teens received services. Of the 7,273 teens, almost 8% were male.

Population Based
Delaware placed population-based efforts in the hands of the "Alliance for Adolescent Pregnancy Prevention" (AAPP). AAPP is a program of Christiana Health Services, which had a contract with DPH, and coordinated statewide adolescent pregnancy prevention initiatives, identified needs, targeted high-risk areas and populations, offered educational workshops and technical support, and also assisted with linking programs and resources.

Local DPH Population Based activities: The following activities were examples of the many activities that took place around this performance measure.
• Information was presented to female teens at local community centers, specifically including pregnancy prevention, abstinence, and birth control methods.
• Field nurses worked with ASK-PAT (Adults Supporting Kids -- Purity Among Teens) at their spring conference, which was aimed at teens. ASK-PAT is collaborative teen pregnancy abstinence based program between DPH and multiple churches, predominantly African American churches, in Kent and Sussex counties.
• Abstinence education was provided at the middle and high school assemblies by Jeffrey

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Teen Hope Additional social work hours providing intense one-to-ne counseling to identify "at-risk" teens based on the Transtheoretical Behavior Change Model (TTM) at six School Based Health Centers (SBHCs).	X			
2. DPH Contracts with a Boys and Girls Clubs and Community Centers to provide structured after school activities covering a variety of topics such as self-esteem and peer pressure.		X		
3. The Bridges Carrerra Model project is an official Dr. Michael Carrera/Children's Aid Society replication project in the Riverside/East Lake communities of the Northeast in Wilmington. The model offers academic assistance including tutoring, family l	X	X		
4. DPH and private agencies provide family planning services, some of which are specifically aimed at teens during teen specific time frames.	X			
5. The Alliance for Adolescent Pregnancy Prevention (AAPP) of Christiana Health Services coordinates statewide adolescent pregnancy prevention initiatives, identifies needs, targets high-risk areas and populations, conducts a media campaign, offers educ			X	X
6. Wise Guys is an adolescent male responsibility program that uses an established Wise Guys curriculum over a ten-week period. The program promotes character development and prevention of adolescent pregnancy			X	

by teaching young males self-responsibilit				
7. The Delaware Partnership for Positive Youth Development and the Kent and Sussex Community Health Outreach are initiatives working closely with each other to involve youth in the planning, development, and implementation of programs and activities tha			X	
8. DPH Health Educators/Trainers participated in the following community outreach activities: Provided STD/HIV education to 35 poeple in such settings as Sussex Tech Adult Class and the Seaford House; Held an education program on contraception for 10 pe			X	
9. Health Fairs included: Safe Kids Day, held at the U of D extension service in Georgetown. Over 200 adults, teens and kids attended the event. Literature and personl contact was made on such subjects as nutrition, diabetes, BP and dental.			X	X
10. Middletown School Based Wellness Center (high school) provides pregnancy testing and utilizes that opportunity to intervene on negative tests, referral for family planning, and discussion of family planning including abstinence.	X	X		

b. Current Activities

Direct Service
The chart attached serves as a graphic description of Delaware's strategy for reaching all Delawareans through public awareness efforts, all teens through School-Based Health Centers and educational programs, at-risk teens through family planning, STD prevention and case management, and teen parents through the intensive home visiting program, WIC and Smart Start.
Direct Services
As already described, DPH contracts include the Boys and Girls Clubs of Delaware for "Smart Moves" and "Game Plan", School-Based Health Centers for "Wise Guys" and "Teen Hope" programming.

Enabling Services
Public Health family planning services, 35% of which are teenagers provide services specifically aimed at teens. No teen is charged for services at the Title X funded sites.

The Division's STD clinics provide treatment for every teen as a priority by offering extra counseling following their encounter with the nurse practitioner. The counselor may be the HIV Counselor, a Disease Intervention Specialist, or another nurse. This "high risk counseling" is a straightforward discussion of the client's reported risk behaviors and their potential consequences. Follow-up calls or visits may be provided based on the teen's interest.

School-Based Health Centers (SBHCs), supported by state and Title V funding, operate in 27 of the 29 public high schools and offer preventive health care, mental health and nutrition services to enrolled students along with health education. In addition, six of the centers have funds for the intensive Teen Pregnancy Program initiative, (Teen Hope) and provide the Wise Guy program.

DPH continues to support the Alliance for Adolescent Pregnancy Prevention.

c. Plan for the Coming Year

Direct Services
Delaware's strategy for reaching all Delawareans will continue through public awareness

efforts, all teens through School-Based Health Centers and educational programs, at-risk teens through family planning, STD prevention and case management, and teen parents through the intensive home visiting program, WIC and Smart Start.

DPH contracts will include a contract with Children and Families First to open "A Resource Center" (ARC) site in Newark, DE. Newark was identified as a high need area for counseling and reproductive health services for teens. The site will be funded through Family Planning Title X funds and include a subsidy from Teen Hope state general funds. Additional programming will include the Boys and Girls Clubs of Delaware for "Smart Moves" and "Game Plan", School-Based Health Centers for "Wise Guys" and "Teen Hope" programming, as well as a continuum of abstinence programs targeted to middle school students.

Enabling Services
Public Health family planning services will continue to provide services specifically aimed at teens. No teen will be charged for services at the Title X funded sites.

The Division's STD clinics will continue to treat every teen as a priority by offering extra counseling following their encounter with the nurse practitioner. The counselor may be the HIV Counselor, a Disease Intervention Specialist, or another nurse. Follow-up calls or visits may be provided based on the teen's interest.

School-Based Health Centers (SBHCs) supported by state and Title V funding will continue to operate in 27 of 29 public high schools and offer preventive health care, mental health and nutrition services to enrolled students along with health education. There are plans to implement an additional wellness center during FY 06. In addition, six of the centers will have funds for the intensive Teen Pregnancy Program initiative, (Teen Hope) and provide the Wise Guy program.

DPH will continue to support the Alliance for Adolescent Pregnancy Prevention.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	17	18	19	35	35
Annual Indicator	14.5	14.1	34.0	30.7	21.4
Numerator			351	464	286
Denominator			1032	1512	1338
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual					

Performance Objective	35	35	35	35	35

a. Last Year's Accomplishments

Infrastructure Building
Title V did not have direct responsibility for this measure although Title V dollars supported a dental assistant position providing services in the Southern two counties. However, the Division of Public Health took a lead role in planning the improvement of services to the Medicaid population. As described in the 2000 Needs Assessment, dentists remain in short supply.

The Division of Public Health used SSDI funds to complete a comprehensive intraoral screening of 3rd grade students. It also included a survey on determinants and behavioral characteristics. In addition to the survey, all identified children, in need of urgent care, received that care.

The dental loan repayment program attracted another dentist to Kent County, and an award was offered to attract another dentist to Sussex County.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Data is being reviewed and analyzed from the needs assessment completed on third grade school children.				X
2. The Division of Public Health continues to coordinate dental screening for the Special Olympics program.			X	
3. The Division of Public Health clinics offer comprehensive dental care for thos in need.	X			
4. The dental loan repayment program will continue in an effort to attract more dentists to needy areas.				X
5. Dental hygiene presentations are included in DPH community youth trainings.			X	
6. At multidisciplinary assessment developmental physician checks mouth/teeth and reviews brushing with family.	X			
7. Speech pathologist discusses reducing bottle, pacifier use with family as needed. Information on bottle mouth is distributed in English and Spanish.	X	X		
8.				
9.				
10.				

b. Current Activities

Infrastructure Building
The dental program completed a school screening and sealant program. Significant barriers being addressed are the licensure issues of dental hygiene supervision for these programs, as well as funding resources.

The Division coordinated a fifth annual dental screening program for Special Olympics. A

training program to prepare dentists in treating persons with special needs is being developed. The Division also sponsored a professional education program on Tobacco Cessation in Dental Offices.

Delmarva Rural Ministries opened its dental clinic in Dover.

Modernization of one DPH dental clinic was completed in December 2004 that doubles its capacity for treating children. DPH hosted an Oral Health Summit in December 2004 and a Head Start forum in June 2005.

The Infant Mortality Task Force report included a recommendation for pregnant women to receive comprehensive oral health care. DPH was awarded the State Oral Health Collaborative grant for improving oral health infrastructure. This enabled the acquisition of a dental public health hygienist and the school sealant program.

The Dental Program inaugurated the school sealant program for the school year 04-05. 15 schools were visited to conduct dental screenings and 1093 sealants were placed. Sealants are also placed on children in the DPH dental clinics, but data is not tabulated by grade level.

The DPH dental clinics continue to provide comprehensive dental care for approximately 8500 children each year. The clinics provide school-linked services to 75 schools overcoming many of the logistical barriers. Private dentists provided care for approximately 10,000 children while DPH clinics saw the remainder.

An example of the success came with the implementation of the first of its kind, Delaware Seal-a-Smile program. The program is geared toward providing an oral exam, oral health education, application of sealants and referral, for those in need of urgent dental care.

c. Plan for the Coming Year

Infrastructure Building
Plans continue for the school screening and sealant program. Significant barriers that are continuingly being addressed are the licensure issues of dental hygiene supervision for these programs, as well as funding resources.

The Division will coordinate a sixth annual dental screening program for Special Olympics. A training program will continue to prepare dentists to treat persons with special needs.

The DPH dental clinics will continue to provide comprehensive dental care for approximately 8500 children each year. The clinics will provide school-linked services to 75 schools that overcome many of the logistical barriers.

The Dental Program will continue with its modernization of clinics, focusing on the clinic at Shipley State Service Center.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and					

Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	3.3	3.3	3.2	3.2	3.2
Annual Indicator	4.4	4.3	2.8	2.8	2.8
Numerator	33	33	23	23	23
Denominator	751863	768086	816490	821990	821990
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.5	2.5	2.5	2.5	2.5

Notes - 2002

Statistics for deaths by motor vehicle crashes are based on 5 year running averages because of the overall small numbers. Vital Statistics data for 2002 will not be available until next year.

Notes - 2003

2003 Data not available at this time. This data will be available at this time next year.
An issue by our Vital Statistician was made that for year 2003 Delaware should be using ICD 10 and a four year average.

The data entered is based on the prior year.

Notes - 2004

2004 Data not available at this time. This data will be available at this time next year.
An issue by our Vital Statistician was made that for year 2004 Delaware should be using ICD 10 and a four year average

The data entered is an estimate based upon the prior year.

a. Last Year's Accomplishments

Enabling
The DPH clinic staffs in Northern and Southern Health Services supplied car safety seats to their clients through a program coordinated with the Division of State Service Centers. Home visiting and clinic staffs advised and provided education to families regarding use of car seats and seatbelts. Child Development Watch included information about car seats and air bag dangers in all intake packets.

Child Development Watch collaborated with the Office of Emergency Services for Children to obtain new car seats for the transport of children for medical appointments.

A Public Health nurse was appointed to the Delaware Coalition for Injury Prevention providing opportunities for field staff to educate clients on pertinent safety issues.

Population Based
Delaware continued to have a Safety Seat Loaner program at the fourteen State Service Centers. The State Service Centers provided health related services targeting low income families in the state. The Delaware Emergency Medical Services for Children (EMSC) MCHB/HRSA grant funded the purchase of safety seats for the Centers in 1998. EMSC replenished the program with 179 seats in the summer of 2002. Through another National

Highway Traffic Safety Administration grant, the Office of Highway Safety provided 50 booster seats for the program. Center personnel were trained to provide instruction to families regarding the seats. As of June 2005 there are approximately 25 seats left from the 179 in 2002. So 154 seats were loaned to low income families in Delaware over a three year period.

Each of the three counties in Delaware now have permanent fitting stations available by appointment for families to obtain instruction on child safety seat fitting.

EMS for Children (EMSC) continues to serve as the lead agency for Risk Watch injury prevention, which was present in 740 classrooms reaching over 16,400 students statewide. A.I.duPont Hospital for Children continues to pay for a full time coordinator of the Risk Watch program.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The DPH clinic staff in Northern and Southern Health Services supply car safety seats to their clients through a program coordinated with the Division of State Service Centers. Home visiting and clinic staff advise and provide education to families			X	X
2. Delaware continues to have a Safety Seat Loaner program at the fourteen State Service Centers. The State Service Centers provide health related services targeting low income families in the state.			X	X
3. EMS for Children (EMSC) is the lead agency for Risk Watch injury prevention, which is in 740 classrooms reaching over 16,436 students statewide.			X	
4. An assessment of child safety is performed with each visit to immunization clinics. Appropriate educational opportunities are provided according to assessed need.		X		
5. DPH purchased booster seats for use in assistance with new state regulations.			X	X
6. Community Health Services/NHS has appointed an RN III to represent NHS on the Delaware Coalition of Injury Prevention.			X	
7. An assessment of child safety is performed with each visit to the Child Health Clinic and Home Visit under the Smart Start/Kids Care Programs.		X		
8. An assessment of child safety is performed with each visit to the immunization clinic.		X		
9. The Child Death Review Committee reviews the deaths of all children in the state of Delaware to determine the preventability of their death. Recommendations from the committee for system changes are presented to the Governor.				X
10.				

b. Current Activities

Direct Services
DPH nurses and other staff continue to supply car safety seats and to instruct clients on how to use them.

Population-Based Services

The "Safety Seat Loaner" program is still in the state service centers for low-income families. In the past year, the Delaware Office of Highway Safety has established permanent fitting station in all three counties. The fitting stations are in central locations where families can go and get education from certified Child Passenger Safety Technicians. Parents are referred to these fitting stations to get technical information about properly securing children in appropriate safety seats.

"Risk Watch" is a comprehensive injury prevention program developed by the Nation Fire Protection Association that addresses the top eight risk areas that kill or injure children in Delaware. The eight age appropriate injury lessons in "Risk Watch" are: Motor Vehicle, Bike and Pedestrian, Fire and Burn, Fall, Choking and Strangulation, Poisoning, Drowning, and Firearms. Schoolteachers and community experts in each of the injury areas present the program in the classroom. Delaware Risk Watch is now in 740 classrooms being delivered to 16,436 students statewide. Delaware uses pre-test, post-test methodology to evaluate the effectiveness of "Risk Watch". The test measures safety knowledge gained comparing before the program to after the program. Average knowledge gain for Delaware school children is approximately seven percent.

The yearly EMSC Delaware "SAFE KIDS" Coalition Childhood Injury Prevention Conference was held June 15, 2005. Approximately 77 people attended from across the state. Teachers, emergency medical service personnel, and childcare providers attend this conference each year. The conference included presentations on all terrain vehicle safety in children, child abuse and gun safety. Evaluations were over all positive.

c. Plan for the Coming Year

The "Safety Seat Loaner" program will remain in place and Public Health and Social Services staff will continue to support the safety seat programs. We plan to pursue funding to replenish the supply of seats. "Risk Watch" will be implemented in two hundred more classrooms through the recruitment of more schools in Delaware.

A new Injury Prevention Epidemiologist has been hired by the Office of Emergency Medical Services in the Division of Public Health. Her role will be leading the state wide Injury Prevention Coalition and developing an injury surveillance system of all populations.

A self-learning CD-ROM based course was developed through the University of Delaware to educate health care providers regarding injury prevention. The course will cover all age groups. We will pilot the course in the fall of 2005.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	63	67.9	67.9	67.9	68
Annual Indicator	61.0	62.0	63.2	82.2	55.9

Numerator	6486	7047	7425	9108	6334
Denominator	10641	11361	11749	11083	11337
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	68	68	68	68	68

Notes - 2002

The data comes from the Newborn Screening Program. Included in the total are women who use breast and lactose formula or breast and soy formula. Women are often given formula whether they plan to use it or not and it is noted at hospital discharge. Also, there are some cases where a supplemental formula is recommended.

Notes - 2003

The data comes from the Newborn Screening Program. Included in the total are women who use breast and lactose formula or breast and soy formula. Women are often given formula whether they plan to use it or not and it is noted at hospital discharge. Also, there are some cases where a supplemental formula is recommended.

a. Last Year's Accomplishments

Direct Services
Clients continued to receive encouragement, information, and education from WIC, Family Planning, and Smart Start visits in the home.

Population-Based
The WIC program supported the reinforcement of the WIC National Breastfeeding Campaign, Loving Support Makes Breastfeeding Work through local media, and the distribution of pins, pens, banners, posters, baby blankets, breastfeeding resource texts, and other marketing materials to those agencies, employees, participants and facilities that participated in the project.

• WIC ordered and distributed over 100 copies of professional resource books for OB & pediatric offices as well as the Visiting Nurses Association, the Wilmington Adolescent Pregnancy Center, and maternity hospitals Labor and Delivery and nursery nurses' stations. Breastfeeding informational materials in English and Spanish for a variety of age and reading levels were distributed through: WIC clinics, health fairs, school wellness fairs, A. I. duPont Hospital for Children, Wilmington Hospital's Adolescent Pregnancy Center, and the Resource Mothers program. Other item distributed were; Loving Support promotional items for use in doctors' offices and clinics and included pens, mouse pads, water bottles, "post its," coffee mugs, and framed prints of breastfeeding mothers and babies.

• WIC had baby blankets embroidered with the multicolored Loving Support Makes Breastfeeding Work logo for distribution to breastfeeding women in clinics and through state maternity hospitals. World Breastfeeding Month (August) 2002 was celebrated in WIC clinics by distributing night-lights with the Loving Support logo.

• WIC ran a billboard campaign throughout the state with the Loving Support logo. WIC contracted with three theaters (one in each county) to run the logo as a slide presentation, before the feature films. There was radio advertising on four stations through the state.

• There were five breastfeeding/breast pumping rooms established in the state at various public health locations.

WIC's Breastfeeding Coordinator held several in-services with nursing contact hours at "lunch & learn" sessions in the Dover area. She also completed presentations to nursing and dietetic students at the University of Delaware, Delaware State, and Delaware Technical and

Community College.
WIC sponsored a breastfeeding conference in New Castle County for dietitians, nurses, and lactation consultants.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The WIC program supports the reinforcement of the WIC National Breastfeeding Campaign, Loving Support Makes Breastfeeding Work through local media, and the distribution of pins, pens, banners, posters, baby blankets, breastfeeding resouce texts, and				X
2. Clients receive encouragement, information, and education from WIC, Family Planning, and Smart Start visits in the home.	X			
3. WIC contracts with the three theatres to run the Loving Support Makes Breastfeeding Work logo as a slide prior to feature films.		X	X	
4. Presentations by the Breastfeeding Coordinator are ongoing.			X	
5. Breast feeding is a topic included at multidisciplinary assessment in nutrition discussions. DPH facilitates obtaining breast pumps, special formulas as needed for special needs infants.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct Services

Clients continue to receive encouragement, information, and education from WIC, Family Planning, and Smart Start visits in the home.

Population-Based

World Breastfeeding Month, August 2004, celebrated in WIC clinics by distributing child size spoons and forks, outlet covers and stickers all with the Loving Support logo.

WIC continues to contract with Comcast for the Loving Support logo on billboards in Sussex County, Delaware. WIC also purchased a book entitled, "Why Should I Nurse My Baby," (English and Spanish versions) to be given out to all prenatal women on the WIC program who are interested in breastfeeding.

A breastfeeding proclamation was written by the breastfeeding coordinator and was signed by Governor Minner in August 2004. The breastfeeding proclamation for 2005 has already been written and will be signed by Governor Minner in the near future.

A Loving Support ad was featured in the Delaware Today magazine as well as in the Delaware State News for Mother's Day.

Presentations by the Breastfeeding Coordinator continue.

Additional breastfeeding/pumping stations have been established in the state service centers, including the James Williams building in Dover, Delaware.

c. Plan for the Coming Year

Direct Services

Clients will continue to receive encouragement, information and education from WIC, Family Planning and Smart Start visits in the home. The program will provide supplemental food as well as nutrition screening and education to at-risk, low-income, pregnant, and postpartum and breastfeeding women, infants and children younger than five (5) years old. In addition, WIC will also provide health assessments and counseling, breastfeeding support and referrals to other programs.

Population Based

World Breastfeeding Month will be celebrated annually in WIC clinics. WIC will continue to purchase ads in the local newspaper to promote and support breastfeeding.

WIC will continue to distribute books and other promotional materials to all WIC participants.

Presentations by the Breastfeeding Coordinator will continue and additional breastfeeding/pumping stations will be established in the state service centers.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	80	85	99	99	99
Annual Indicator	81.4	97.9	98.0	98.0	98.1
Numerator	9421	11040	11526	10861	11889
Denominator	11574	11272	11757	11083	12121
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

This is a performance measure, which was the prime responsibility of hospitals; however, Title V staff provided collaborative support in the area of data collection and public awareness. DPH

also provided audiology services.

Infrastructure Building
Title V staff in the Family Health Services Branch worked with the Women's and Reproductive Health Branch staff (Newborn Screening) in the development the system for screening newborns for hearing impairments

Two grants were approved to support this effort. The Centers for Disease Control Early Hearing Detection Intervention (EDHI) Grant started last September. This new program set in place the infrastructure to link the hearing results from the hospitals with the current metabolic newborn screening program and provide tracking and follow-up.

The Universal Newborn Hearing Screening and Intervention grant funded through the MCH Bureau assisted in purchasing necessary equipment for the hospitals and program to track and follow-up abnormal hearing screenings and provided educational materials for parents and providers in English and Spanish.

Both the CDC and the MCH renewed grants to Delaware Public Health/ Section of Community Health Care Access to fund the DE Newborn Hearing Screening Program. As planned, a Coordinator of this Program and an Application Support Specialist were hired.

Regulations were signed for the Birth Defects Surveillance and Registry Program requiring the reporting of all birth defects including hearing impairments. Hearing screening equipment and the ability to report the results of the screening to the NHS Program, were identified for the six birthing hospitals, the Birth Center, A.I.duPont Hospital, and the Amish midwife. Equipment and software were provided to the birth sites that were unable to find funding. A training session was conducted for all hospitals and others who used the OZ tracking system for reporting. All of these facilities continued to screen newborns completing approximately 96% of the Delaware babies.

Educational materials were developed provided for parents and providers, which described the importance hearing screening of newborns. This information was provided in both English and Spanish. A provider's manual with inclusive information as to the recommended guidelines for screening, testing, follow-up, referral, and treatment was developed. A parent manual for diagnosed hearing impaired infants was also developed.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Delawae Infant Hearing Assessment and Intervention Program Committee continues to meet quarterly to address the hearing screening system.				X
2. A parent's guide for hearing services was finalized.				X
3. A professional guideline and standards for hearing services was finalized.				X
4. The Newborn Hearing Screening Program is collecting data through a Central Reader's Station at the program office.				X
5. Field nurses ensure that families follow-up with specialist when infants fail their hearing tests while in the hospital.	X	X		
6. A Child Health Practitioner completes full physical on all DPH eligible	X			

participants. Hearing Screenings are completed at first visit.				
7. DPH routinely uses OAE screener for hearing problems, then refers to PCP for follow-up.		X		
8. DPH Facilitates/Coordinates follow-up on results such as BAER.		X		
9.				
10.				

b. Current Activities

Infrastructure Building
Delaware held a conference for parents, pediatricians, family practitioners and other medical providers. Some of the topics discussed at the conference were Genetics, Research Developments, Legal Rights and Communication Options. A parent panel discussed their personal stories, triumphs, difficult decisions and answered questions from the audience.

The providers' Manuals and Parents' Manuals are being distributed to all pediatricians, and audiologists. In addition, the Parents' Manual will be distributed to the parents of all babies diagnosed with deafness or hearing loss. Educational brochures in both English and Spanish continued to be widely circulated to providers, new mothers, and mothers-to-be.

Both the MCH grant and the CDC grant for Newborn Hearing Screening were renewed for 2004, thus enabling Delaware Public Health to continue the Newborn Screening Program. The CDC grant ends in August of 2005. A re-application was not approved.

Regulations for the Birth Defects Surveillance and Registry Program require the reporting of all birth defects including hearing impairments. All Delaware birthing sites voluntarily screen the hearing of newborns and report results using a system set up by the Newborn Screening Program office. The results of the screening from the six birthing sites, the tertiary care hospital for children, the Birth Center and the midwife for the Amish indicated a screening rate of approximately 93% prior to one month of age for the 12,000 DE babies. After more testing, 21 babies were diagnosed as either deaf or hard of hearing.

Ninety-eight percent (98%) of the babies born in Delaware were screened for Newborn Hearing. The Newborn Hearing Screening program identified twenty-one infants with a hearing loss in 2004.

The Hearing Aid Loaner Program loaned out hearing aids to two (2) babies diagnosed with a hearing loss. Program information was placed on the Newborn Hearing Screening website to ensure the utilization of the program.

A data committee was developed to undertake our ongoing problems with definitions, and how to break out the data. The data committee will decide what "lost to follow up" means and what data should be reported at the state and hospital level.

c. Plan for the Coming Year

Infrastructure Building
The program will be planning another conference for early 2006. The focus for the conference will be technology.

The data committee will continue to meet. Once issues have been resolved quality assurance visits will be conducted throughout the state. The main goal continues to be the diagnosis and amplification of 100% of the babies who do not pass the screening

With the DE Newborn Hearing Screening Program in place all DE babies who are referred for diagnostic evaluation as a result of their hearing screening will be followed through the Program Office. The Central Reader's Station at the program office records all pertinent information and the Newborn Hearing Coordinator contacts parents, providers, and the Medical Home. Birthing facilities receive Quality Assurance Reports from the Program and scheduled visits. The program aims to achieve a goal of 100% diagnosis for all babies referred and 100% amplification for all babies diagnosed with deafness or hearing loss.

The Hearing Aide Loaner Program will continue to provide aids for babies whose families require assistance in the early months of amplification.

The MCH grant ends in Marchof 2006 and a renewal application will be submitted.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	13	12	11	8.2	8.2
Annual Indicator	12.8	10.7	8.2	8.5	8.5
Numerator	24907	23300	13500	17090	18613
Denominator	194587	217000	164073	201054	218980
Is the Data Provisional or Final?				Provisional	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.2	8	8	8	8

Notes - 2003
Projection for the denominator "number of children in the state under the age of 18" may change by year end.

a. Last Year's Accomplishments

Enabling Services
Well child clinics provided for uninsured children in several public health clinics. Services included EPSDT screens and immunizations. Referral for ongoing primary care services were encouraged, usually to the federally qualified health centers.

School-Based Health Centers were located in 27 of 29 districts in the state. Although these centers did not provide primary care, they referred uninsured adolescents to primary care physicians. Frequently to Medicaid and the Delaware Healthy Children program eligibility.

Infrastructure Building

The Medical Society of Delaware received a Robert Woods Johnson grant Covering Kids and Families. Public Health staffs worked closely with them throughout the grant process. This proposal contained statewide initiatives and local projects that focused on outreach simplification, coordination, and children and adults with medical services.

Local projects utilized lessons learned from the "Covering Kids Program" and fully engaged two communities: the medical community and the childcare community. In each local project, staff resources were dedicated to assisting children and adults through the application and enrollment process and dedicated staff at the Delaware Division of Social Services served as direct liaisons to ensure ongoing quality checks and more timely application processing.

In the "medical champion" project, Medical Society of Delaware physicians, and their patients were able to access a central resource for application assistance. In this model, patients were encouraged to make application for available resources and to use the broad array of health and social services more effectively. In the "childcare champion" project, child health care consultants were available to 2000 childcare facilities across the state to promote health and safety to employees and the families they serve. The health consultation system was established through the Healthy Child Care America grant.Another lead agency, the Family and Workplace Connection, was the contractor for this portion of the project.

Another federal grant, the Primary Care grant, was utilized to retain the grant-funded staff that coordinated the Covering Kids pilot initiatives. The roles of each of these two individuals focused on community-based education to consumers and organizations about public insurance programs and as well the importance of primary and preventive care.

Coordination with childcare providers improved because of the Healthy Child Care America 2000 grant. The newsletter, distributed 3 times a year to all childcare provider staff, continued to include information regarding insurance.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Well child clinics are provided for uninsured children in several public health clinics. Services include EPSDT screens and immunizations and referral to primary care physicians.	X	X		
2. School Based Health Ceters are in 27 of 29 districts in the state. Although these centers do not provide primary care, they refer uninsured adolescents to primary care physicians.		X		
3. The Medical Society of Delaware through a Robert Woods Johnson grant Covering Kids and Families. Public Health staffs work closely with them and will continue to do so throughout the grant process. This proposal contains statewide initiatives and l		X	X	X
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

In addition, this is not an area, in Delaware, for which Title V has direct responsibility. Increasing the numbers with insurance coverage depends on a variety of factors such as implementation of SCHIP and Medicaid enrollment.

Enabling
Referrals continue to be made to the duPont Pediatric Clinics when a child does not have insurance or a medical home. In addition, referrals to Medicaid and the Delaware Healthy Children Program are made by all DPH programs (CDW, Kids Kare, immunizations etc.) when it is determined that children under their care do not have a source of insurance. DPH staff also refers and help with applications to private insurance where applicable.

School-Based Health Centers provide referrals to primary care physicians for adolescents who do not have a physician.

Infrastructure Building
The Nursing Director for the Division was assigned to serve as the DPH representative for the Covering Kids and Families initiative and continues to play an active role. Title V staff work with Families and Workplace Connection to enhance the health consultation systems childcare providers.

c. Plan for the Coming Year

Enabling
Referrals will continue to be made to the A.I.duPont Pediatric Clinics when a child does not have insurance or a medical home. In addition, all DPH programs (CDW, Kids Kare, Immunizations, etc.) work to ensure that children under their care are referred to Medicaid and to the Delaware Healthy Children Program when it is determined that they do not have a source of insurance. DPH staff will also refer and help with applications to private insurance where applicable.

School-based Health Centers will continue to provide referrals to primary care physicians for adolescents who do not have a physician.

Infrastructure Building
The nursing director for the Division was assigned to serve as the DPH representative for the "Covering Kids and Families" initiative and will continue to play an active role. Title V Staff will work with Families and Workplace Connection to enhance the health consultation systems childcare providers.

Coordination with childcare providers is improving as a result of the States Early Childhood Comprehensive Systems grant. The newsletter that is distributed three times each year to all childcare providers and staff will continue to include information regarding insurance.

The Interagency Coordinating Council (ICC) has created a subcommittee to address this performance measure of uninsured and under-insured children in Delaware. The subcommittee will be convening meetings with Medicaid late summer. The former Director of CSHCN, Dennis Rubino, is a member of ICC and will be an active member of the subcommittee.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a*

service paid by the Medicaid Program.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	34	35	36	37	38
Annual Indicator	54.9	84.6	94.7	96.2	94.8
Numerator	37474	58374	69362	71589	78004
Denominator	68281	69021	73252	74384	82292
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	95	96	96	96

a. Last Year's Accomplishments

Enabling
What was stated in NPM #13 regarding insurance coverage for children and non-Medicaid coverage applies for this measure. In addition, the Division of Public Health continued to provide liaisons with the A.I. duPont pediatric clinics across Delaware.

Kids Count gathered and analyzed data related to insurance and Medicaid enrollment.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Division of Public Health continues to provide liaisons with DuPont pediatric clinics.		X	X	
2. Encounter data is being collected by Medicaid and their managed care organizations.				X
3. Kids Count is gathering and analyzing data related to Medicaid enrollment.				X
4. Children are seen in our Well Child Clinic on an appointment basis. After the initial visit, they are provided with a Medicaid package or referred to the state Children Health Insurance program so that they can find a medical home.	X	X		
5. DPH assists with application and provides information and support for families in appeal situations.		X		
6. DPH assists PCP and providers in understanding and using the Medicaid benefit.		X	X	
7.				

8.				
9.				
10.				

b. Current Activities

Enabling
The liaison activity of the Division of Public Health continues with the A.I. duPont pediatric clinics.

The Kids Count reports are reviewed annually related to insurance and Medicaid enrollment. Encounter data is gathered, reviewed, and analyzed by Medicaid and their managed care organizations.

c. Plan for the Coming Year

Enabling
Title V supported clinic and field staff will refer to Medicaid when they determine that a child may be eligible. DPH will continue to provide liaisons with A.I.duPont Pediatric Clinics that refer children through Child Development Watch and the Women Infants and Children (WIC) program.

Kids Count will continue to gather and analyze data related to insurance and Medicaid enrollment. The 2005 Kids Count reports will be reviewed, as related to insurance and Medicaid enrollment. Encounter data will be gathered, reviewed, and analyzed by Medicaid and their managed care organizations

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.5	1.5	1.5	1.5	1.4
Annual Indicator	1.9	1.8	1.9	1.9	1.9
Numerator	982	981	1012	1068	1068
Denominator	52685	53280	54116	54879	54879
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.4	1.4	1.4	1.4	1.4

Notes - 2002
Vital statistics data from 2002 will not be available until next year.

Notes - 2003

2003 Data not available at this time. This data will be available at this time next year.

a. Last Year's Accomplishments

Infrastructure Building

As a result of our high infant mortality rates, DPH established the Infant Mortality Internal Workgroup. The Work Group's Data Committee concentrated on the excess or increase in deaths and on further examination of the data for all of the deaths. In conjunction with the Perinatal Board's Scientific Committee, the following was determined regarding the excess or the increase in the mortality rate:

• Primarily, increase was due to an increase in the mortality rate among very low birth weight (VLBW) infants

• Secondarily, it was due to a small increase in the proportion of VLBW babies among all live births.

DPH worked with the CDC and the Perinatal Board to determine the causes. Since the possible causes were in the early states of investigation, no information was released. It is clear, however, that infants are being born smaller and in poor health. The excess infant VLBW deaths are to older married women who enter care during the first trimester and are educated and insured. Overall, our data showed that the large majority of infant deaths are to women who are poor, lack a high school education, are uninsured, and have other risk factors such as tobacco use.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Perinatal Board worked with the March of Dimes (MOD) on their Prematurity Campaign. The Board is particularly addressing emotional health issues and how they affect pregnancy outcomes.				X
2. Christiana Care Health Services received Community Centers for Excellence in Women's Health. This grant will help to coordinate services to provide integrated, culturally competent services to 3,000 high rish, low income, and underserved women in Ne		X		X
3. DPH is a provider of services under the SMART Start program. Assessment, education/teaching, monitoring of pregnancy to reduce infants with low and/or very low birth weight is a goal of this program.	X	X	X	
4. Family Planning clinics offer pregnancy testing by appointment daily in hopes to offer counseling, education and referral to OBGYN and Smart Start services to increase early entry into care.	X	X		
5. DPH encourages PCP prenatal follow-up for pregnant mothers.		X		
6. The Infant Morality Task Force has reviewed the issue and made recommendations.				X
7.				
8.				
9.				
10.				

b. Current Activities

Population-Based

The Perinatal Board works with the March of Dimes (MOD) on their Pre-maturity Campaign.

The Pre-maturity Campaign includes a speaker's bureau, meetings with legislators, and news events. The Board is particularly addressing emotional health issues and how they affect pregnancy outcomes. As a result, the Board joined forces with the Mental Health Association, Christiana Care Health Services, the Perinatal Association, and the March of Dimes to implement a conference addressing emotional health and to ensure that Resource Mothers are trained in screening for these issues. As a result of the 2004-2005 Infant Mortality Task Force, the Perinatal Board is transitioning to becoming a legislated entity to be known as the Healthy Mother and Infant Consortium. A committee is working on the bylaws and the goals and objectives for the Consortium.

Infrastructure Building:
DPH continues to work with the Perinatal Board in its transition, Christiana Care Health Services, and the CDC to determine the root causes of deaths to VLBW babies.

Christiana Care Health Services received a Community Centers for Excellence in Women's Health in the fall of 2002. This is a five-year grant through the Department of Health and Human Services to coordinate services to provide integrated, culturally competent services to 3,000 high risk, low income, and underserved women in New castle County. Plans include health professional training to work with the underserved communities, increased leadership, and advocacy skills for the women, and involving the community by increasing their health knowledge base. Also planned are a needs assessment and a program evaluation. The needs assessment will help to plan educational opportunities that they will offer and if possible address barriers to care. Planners hope that one result of this effort will be healthy women with improved birth outcomes. DPH is an active participant on the Community Centers for Excellence in Women's Health steering committee.

The Infant Mortality Task Force was implemented with the following goals to include:
Defining the infant mortality status of Delaware as compared to the nation and the region,
Defining the disparities among races related to infant mortality and determining the reasons for the increasing disparity gaps.
Identifying risk factors and underlying etiologies when possible,
Reviewing scientific literature with the purpose of determining risk factors for infant mortality and best practices for prevention and intervention.
Determining and assessing the impact of relevant risk factors,
Increasing awareness of the scope of the problem among government officials, medical professionals, and the public.
Improving coordination between and among public and private sector agencies.
Recommending critical changes to the profile of, operations of, and support of the Delaware Perinatal Board.
Identifying areas requiring additional research and education.

The results of the "Infant Mortality Task For

c. Plan for the Coming Year

Population-Based
The Delaware Perinatal Board will continue to work with the March of Dimes (MOD) on their Pre-maturity Campaign. The Board will work with the Mental Health Association Services, Children and Families First, and the March of Dimes to implement a conference addressing emotional health and to ensure that Resource Mothers are trained in screening for these issues.

Infrastructure Building
DPH will continue to work with the Delaware Perinatal Board with its transition to becoming the Healthy Mother and Infant Consortium, Christiana Care Health Services, and the CDC to

determine the root causes of Deaths to Very Low Birth Weight (VLBW) babies.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	5.8	5.8	5.6	5.6	5.5
Annual Indicator	6.4	7.0	6.9	8.3	
Numerator	17	19	19	23	
Denominator	265668	270586	274188	276711	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.5	5.5	5.4	5.4	5.4

Notes - 2002

Suicide for teens is measured using 5 year running averages because of the small numbers. 2002 data will not be available until next year.

Notes - 2003

2003 Data not available at this time. This data will be available at this time next year.

Notes - 2004

2004 Data not available at this time. This data will be available at this time next year.

a. Last Year's Accomplishments

Direct Services
Public Health clinic services provided depression screening during any contact with youth regardless of the service. Families who experienced a death of a teenager related to suicide were provided support from Public Health field staff. Grief counseling and referral to appropriate agencies was provided as needed.

Adolescents enrolled in the School Based Health Centers (SBHC) were eligible for mental health counseling. Students have a brief review of behavioral risk factors with sports physicals, and other preventive care visits. Parents, teachers, friends, the school nurse or guidance counselors referred students for a mental health assessment. Students identified as at-risk for suicide were referred to the appropriate providers or for hospitalization.

SBHCs served as an important resource for teens with emotional concerns. In FY 2002, there were 18,161 visits where emotional concerns were the primary diagnosis. This increased from last year's visit number of 15,798. These visits were 36% of all primary diagnosis visits. Other diagnoses were tracked when a student came in for one concern but another concern was also

identified. In these cases, there were 29,190 diagnosis made for emotional concerns. Out of this number, suicide ideation was diagnosed a total of 233 times or about 0.8 % of all diagnoses based on emotional concerns.

The Division of Public Health does not provide staffing support for the Child Death Review Commission. This function was assumed by the Department of Services for Children, Youth, and their Families. The Department Secretary served on the Commission and several public health field staff served on the regional review committees.

The Division of Public Health participated on the JUST for Youth coalition to support Gay, Lesbian, and Bisexual youth who are prone to suicide ideation. A comprehensive strategic plan was developed. Thus far drafts addressed expanding the coalition, established support for the collection of violence and victimization data about lesbian, gay, bisexual, and transgender youth, identified the set of critical groups to take action within their own settings, and expanded cooperation within schools, communities and family organizations to decrease victimization and its impact on mental health.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Public Health clinic services provide depression screening during any contact with youth regardless of the service. Families who have experienced a death of a teenager related to suicide are provided support from Public Health field staff.		X		
2. Adolescents enrolled in the SBHC are eligible for mental health counseling. Students identified as at-risk for suicide are referred to the appropriate providers or for hospitalization.	X	X		
3. The Division of Public Health participates on the JUST for Youth coalition to support Gay, Lesbian, and Bisexual youth who are prone to suicide ideation.				X
4. DPH staff observes family members for possible MH issues and refers as needed for follow-up to DFS, CMH.		X		
5. Middletown School Based Wellness Center (high school) provides mental health services for thos students enrolled with the center. Students identified as at-risk for suicide are referred for professional services including hospitalization.	X	X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct and enabling
DPH clinic staff and SBHCs continue to assess adolescents and refer when needed.

Infrastructure Building
DPH continues its involvement with the Just for Youth initiative.

DPH and the Division of Child Mental Health work collaboratively to examine how services are coordinated for SBHCs.

c. Plan for the Coming Year

Direct Services
Public Health Clinic services will continue to provide depression screening during any contact with youth regardless of the service. Families who have experienced a death of a teenager, related to suicide, will be provided support from Public Health field staff. Grief counseling will be provided as well, with referral to appropriate agencies as needed.

Adolescents enrolled in the School-Based Health Centers will continue to be eligible for mental health counseling. Students have a brief review of behavioral risk factors with sports physicals and other preventive care visits. Parents, teachers, friends, the school nurse, and the guidance counselors can refer students for a mental health assessment. Students identified as at-risk for suicide will be referred to the appropriate providers, or for hospitalization.

The Division of Public Health will continue its participation on the "JUST for Youth" coalition to support Gay, Lesbian, and Bisexual youth who are prone to suicide ideation. A comprehensive strategic plan is in the process of being developed.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	86	90	90	90	90
Annual Indicator	81.2	78.6	77.5	83.3	
Numerator	173	151	172	20	
Denominator	213	192	222	24	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2002
2002 data is not available and will not be available until July, 2004.

Notes - 2003
2003 Data not available at this time. This data will be available at this time next year.

Notes - 2004

2004 Data not available at this time. This data will be available at this time next year.

a. Last Year's Accomplishments

Infrastructure Building
In 1997, the Perinatal Board worked with the delivering hospitals to establish the Perinatal Classification System, which designated Christiana Care Health Services as its Level III facility. All at-risk deliveries are referred to Christiana Care. If necessary, mother and/or infant are transported by ambulance or helicopter from the southern part of the state to the nearest facility.

Infrastructure Building
Handling of at-risk deliveries at other than, level III hospitals were reviewed by the Perinatal Board Standards of Care Committee. Transportation by ambulance or helicopter was reviewed for timeliness and appropriateness

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Handling of at-risk deliveries at other than LevelIII hospitals are reviewed by the Perinatal Board Standards of Care Committee. Transportation by ambulance or helicopter is reviewed mfor timeliness and appropriateness.				X
2. Field Staff involved with high-risk cases encourage prenatals to take OB's advice to deliver at high-risk sites.		X		
3. The transporation of VLB babies is being studied as a result of a recommendation of the Infant Mortality Task Force.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building
DPH Title V continues its support for the Perinatal Board and its activities during its transition to become the Healthy Mother and Infant Consortium.

Title V is involved with the establishment of a Maternal and Child Health Center for Excellence as a ‘virtual' office in making infant mortality and healthy mothers a priority in the state.

c. Plan for the Coming Year

Infrastructure Building
DPH Title V will continue its support for the Delaware Perinatal Board and its activities during its transition to become the Healthy Mother and Infant Consortium.

Title V will continue to play a major role with the establishment of a Maternal and Child Health Center for Excellence as a ‘virtual' office in making infant mortality and healthy mothers a

priority in the state.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	87	87	88	88
Annual Indicator	85.0	87.0	86.8	83.9	83.9
Numerator	9386	9348	9619	9508	9508
Denominator	11046	10747	11083	11337	11337
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2002

Year 2002 data has not been analyzed and the data will not be available until next year's submission.

Notes - 2003

2003 Data not available at this time. This data will be available at this time next year.

Notes - 2004

2004 Data not available at this time. This data will be available at this time next year. This is an estimate based on 2003 data.

a. Last Year's Accomplishments

Enabling
Smart Start continues to be provided to at-risk mothers. The Smart Start program is a statewide cooperative effort between the Division of Public HEalth and Medicaid and its managed care organizations.

Infrastructure Building: Addressing Kent and Sussex Entry into Care Issues

Prenatal care in Southern Delaware is still of concern:
• Physicians are continuing to give up their obstetrical practices. National events have also had an impact with the loss of an OB to the Reserves and Iraq.

• One OB/GYN practice will not accept presumptive Medicaid.

• Nanticoke Maternity Center did close on June 30, 2003. They stopped seeing new patients in mid-June the two hundred existing patients were transferred to the private OBs in Western

Sussex. While all of the current obstetrical practices have agreed to accept Medicaid during this transition, whether they will continue to accept Medicaid or place a cap on the number of Medicaid clients they accept remains to be seen. La Red has entered into an agreement to have OB services available at La Red and Maternity Center clients from Georgetown will be transferred there. La Red is a bilingual comprehensive health care center. The target population of La Red is primarily the minority populations and the underinsured and uninsured of Sussex County.

The Kent County Prenatal Care Committee continues to meet. The committee has been involved in teen pregnancy prevention efforts (see section on the National Performance Measure # 8). In addition, the group was made aware that a specific provider told Medicaid patients that they are unable to accept additional Medicaid clients until they deliver current patients. Patients were directed to call back the following week. The chair has contacted all of the provider groups in Kent County to request their attendance at the meeting and to re-educate OB/GYN care providers on referral resources available to Medicaid patients when the provider is unable to serve them. The OB/GYN offices have attended the meetings in the past but have not recently.

The Division of Public Health continues to support the voucher program in Sussex County but is considering the option of contracting with a private provider to provide the services. During the current year, MCHBG funds have paid for a portion of the dollars needed.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Smart Start is a prevention program designed to address the factors, which may negatively influence pregnancy outcomes. After the initial assessment, a basic package of education and counseling is provided to cover the main components of prenatal an			X	
2. The Kent County Prenatal Care Committee includes representatives from the Division of Public Health, Bayhealth Medical Center, the Kent County private obstetrical practices, and others concerned about adequacy of prenatal care. It meets on a monthly				X
3. The Division of Public Health also supports a voucher program in Sussex County where DPH provides vouchers to cover initial and revisits for patients with no insurance and who are under 250% FPL.				X
4. Family Planning clinics offer pregnancy testing by appointment daily in hopes to offer counseling, education and referral to OBGYN and Smart Start services to increase early entry into care. Upon receipt of referral from Family Planning clinic staff	X	X		
5. The Infant Morality Task Force has reviewed the issue and made recommendations.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Enabling
Smart Start services continue an evaluation of the program currently underway with a final report due within six months.

DPH is currently reviewing the voucher program and is considering contracting with one agency to provide the needed services rather than the vouchers.

Infrastructure Building
Public Health continues its participation on the Prenatal Care Committee.

c. Plan for the Coming Year

Enabling
The Smart Start services will continue during the next year, the evaluation of the program will be completed, reviewed, and analyzed.

Infrastructure Building
Public Health will continue its participation on the Prenatal Care Committee.

DPH Title V will continue its support for the Delaware Perinatal Board and its activities during its transition to become the Healthy Mother and Infant Consortium.

DPH Title V will continue to play a major role with the establishment of a Maternal and Child Health Center for Excellence as a 'virtual' office in making infant mortality and healthy mothers a priority in the state.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of youths reporting smoking 2 or more cigarettes per day on the days they smoked*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	23	22	16.9	16.9	16.9
Annual Indicator		16.9	NaN	16.7	
Numerator		472	0	509	
Denominator		2794	0	3048	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance	16.9	16.9	16.8	16.8	16.8

Objective					

Notes - 2002

YRBS is only undertaken every other year. Therefore, 2002 data will not be available.

Notes - 2003

2003 Data not available at this time. This data will be available at this time next year.

Notes - 2004

YRBS conducted every other year.

a. Last Year's Accomplishments

Enabling

Like all adolescent health measures, while DPH can help to lead this effort, it cannot address these issues alone. Instrumental were the schools, the legislature, SBHC contractor agencies (i.e., Christiana Care Health Services, Bay Health), and parents. In addition, Title V is not the lead DPH agency regarding this issue but is a collaborator with Health Promotion and Disease Prevention, another DPH section.

Work has continued on the following goals for DPH:
• Continuing to provide media, community programs, cessation, and coordination for tobacco use
• Prevention programs related to tobacco-related chronic diseases
• Preventing tobacco use among young people.
• Increasing the proportion of cigarette smokers who attempt to stop smoking.
• Reducing routine exposure to environmental tobacco smoke.
• Increasing the number of Delawareans who strongly disapprove of cigarette use.

Title V continued the emphasis on eliminating use of tobacco through the development and support of the SBHC program

Population Based

• The School-Based Health Centers sponsored a number of activities such as lunch and learn series on the hazards of tobacco use, yoga and smoking cessation, coordination with the Great American Smoke Out and have implemented the Too Smart to Start Program.
• Smart Start advised all clients including teenagers to stop smoking.
• Pamphlets regarding the dangers of smoking were placed in all clinics such as dental, STD, and Child Health clinics. Posters and bookmarks are placed at most clinics.

DPH Health educators and nutritionists provided presentations to schools throughout the school year.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide media, community programs, cessation, and coordination for tobacco use through the Tobacco Prevention and Control Program.			X	
2. Eliuminate the use of tobacco through the development and support of the school based health centers.		X		
3. The Smart Start (reproductive) program will continue to advise clients, especially teenagers, on smoking cessation health benefits.	X			

4. The Division will promote and enforce the state's strict Clean Indoor Air Act.			X	
5. Tobacco use is assessed in each client setting.	X			
6. Health fairs feature tobacco prevention and cessation as a priority discussion with this age group.			X	
7. Trainers/Educators provide smoking cessation classes to the community as requested.			X	
8. A Tobacco Prevention Conf. "Is It Worth It?" was held at DTCC Owens Campus designed for parents, students and community.			X	
9. Students identified in the Middletown School Based Wellness Center (high school) are referred to the counselors. Literature is also available in the medical clinic targeted towards youth and anti-smoking.	X			
10.				

b. Current Activities

Enabling
DPH helped to lead this effort with the schools, the legislature, SBHC contractor agencies (i.e., Christiana Care Health Services, Bay Health), and parents. In addition, Title V is not the lead DPH agency regarding this issue but is a collaborator with the Health Promotion and Disease Prevention Section of DPH.

Work has continued on the following goals for DPH:
• Continuing to provide media, community programs, cessation, and coordination for tobacco use
• Prevention programs related to tobacco-related chronic diseases
• Preventing tobacco use among young people.
• Increasing the proportion of cigarette smokers who attempt to stop smoking.
• Reducing routine exposure to environmental tobacco smoke.
• Increasing the number of Delawareans who strongly disapprove of cigarette use.

Title V focused on eliminating use of tobacco through the development and support of the SBHC program

Population Based
• The school based health centers sponsored a number of activities such as lunch-and-learn series on the hazards of tobacco use, smoking cessation, coordination with the Great American Smoke Out, and implementation of the Too Smart to Start Program.
• Smart Start advised all clients including teenagers to stop smoking.
• Pamphlets regarding the dangers of smoking were placed in all clinics such as dental, STD, and Child Health clinics. Posters and bookmarks are placed at most clinics.

DPH Health educators and nutritionists provided presentations to schools throughout the school year.

c. Plan for the Coming Year

Enabling
Title V will continue the current emphasis on eliminating use of tobacco through the development and support of the SBHC program. We will also continue to incorporate this measure in other programs such as Smart Start, Kids Kare, etc.

Population Based

Comprehensive tobacco control efforts in Delaware will continue without significant changes in the coming year. The state's efforts are coordinated through the Division's Health Promotion and Disease Prevention Section, Tobacco Prevention and Control Program, with funding from the Delaware Health Fund (Master Settlement Agreement funds) and a cooperative agreement from the Centers for Disease Control and Prevention. Total budget is approximately $5 million a year. Additional funds in tobacco prevention go to the Department of Education, the state Attorney General's Office, the state Division of Alcoholic Beverage Control and Tobacco Enforcement, and Tobacco Free Delaware (a Robert Wood Johnson Foundation grant with the American Lung Association of Delaware as the lead agency).

The Delaware Tobacco Prevention and Control Program will focus on several key areas of tobacco control:
1) Prevention of tobacco use, primarily among youth and young adults. Youth programs are coordinated by staff and through contracts with community-based providers, including the American Lung Association of Delaware.
2) Community based tobacco prevention efforts.
3) Smoking cessation, primarily through the toll-free Delaware Quitline.
4) Social marketing and counter-marketing through the media
5) Promotion and enforcement of policy -- including the state's strict Clean Indoor Air Act and youth access laws.

The objectives are guided by the state's Tobacco Prevention and Control Plan, which was published in 2000, and will be updated in 2005. The program will work closely with the Impact Delaware Tobacco Prevention Coalition, the Kick Butts Generation, and other tobacco prevention and control groups in Delaware.

The state's comprehensive Tobacco Prevention and Control Program will continue at essentially the same levels in the coming year. State funding, through the Delaware Health Fund, has increased to about $7 million a year.

Additional emphasis will be placed on college-age young adults and on males (of all demographic groups), who continue to be the demographic groups with the highest smoking prevalence.

State Performance Measure 2: *The percent of youth reporting any use of alcohol in the last 30 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	47	46	46	45	45
Annual Indicator		46.4	46.4	45.4	
Numerator		1300	1300	1384	
Denominator		2803	2803	3048	
Is the Data					

Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	44	44	43	43	43

Notes - 2002

This is YRBS data which is only collected every other year, therefore 2002 data will not be available.

Notes - 2004

Data not available at this time. Will be available this time next year.

a. Last Year's Accomplishments

Direct Services

School-Based Health Centers provided individual counseling for alcohol and for children of alcoholics. They also worked with parents so that parents can speak to their children about this topic. School-based health centers also referred to the Division of Child Mental Health Services and other agencies for services they could not provide, e.g., beyond their capacity, summer time needs, and more intensive inpatient services.

DPH staff, both at clinic visits and during home visits, assessed alcohol use during each client contact. Resources for cessation were suggested. The DPH Trainer/Educator provided educational opportunities regarding alcohol use to the community as requested.

Population Based Services

DPH no longer had the funding to award mini-grants for the SLAM and Start Smart programs. SBHCs provided "Lunch and Learn" series and other activities for the schools related to decreasing alcohol consumption.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. SBHC provide individual counseling for alcohol & children of alcoholics. SBHCs refer to the Div of Child Mental Health Services and other agencies for services they cannot provide.	**X**			
2. DPH staff, both at clinic visits and during home visits, assess alcohol use at each client contact. Resources for cessation are suggested.	**X**	**X**		
3. The DPH Trainer/Educator provides educational sessions regarding alcohol use to the community as requested.			**X**	
4. Since the YRBS is only completed every two years, another survey will be undertaken next year.				**X**
5. Middletown School Based Wellness Center (high school) provides individual counseling to those students enrolled related to alcohol use and children of alcoholics.	**X**	**X**		
6.				
7.				
8.				

9.				
10.				

b. Current Activities

Direct Services
School based Health Centers provide individual counseling for alcohol and for children of alcoholics. They also work with parents so that parents can speak to their children about this topic. School-based health centers also refer to the Division of Child Mental Health Services and other agencies for services they cannot provide, e.g., beyond their capacity, summer time needs, more intensive inpatient services.

DPH staff, both at clinic visits and during home visits, assess alcohol use at each client contact. Resources for cessation are suggested. The DPH Trainer/Educator provides educational sessions regarding alcohol use to the community as requested.

c. Plan for the Coming Year

Direct Services
School Based Health Centers will continue to provide individual counseling for alcohol and for children of alcoholics. They will work with parents so that parents can speak to their children about this topic.

Clinics will continue to provide information regarding dangers of alcohol consumption in a variety of settings.

Population Based
School Based Health Centers will continue to include activities such as a play on substance abuse; "Prom Promise", and discussions with teens regarding substance free lifestyles.

Infrastructure Building

The YRBS analysis will continue. Alcohol use among high school students stayed about the same. The 2003 Youth Risk Behavior Survey (YRBS) reported that 45% of Delaware high school students drank alcohol during the past month.

The annual "Alcohol, Tobacco and Other Drug Abuse Among Delaware Students" study for 2004 will be reviewed and analyzed by the appropriate MCH staff and councils. That study reported that 43% of 11th grade students used alcohol in the past month. The study also showed that 24% of 8th grade students said they drank alcohol in the past month.

State Performance Measure 3: *Percent of youth during the last 12 months who feel so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective		25	25	23	23
Annual Indicator		27.0	27.0	27.4	
Numerator		785	785	831	
Denominator		2906	2906	3034	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	23	23	23	23	23

Notes - 2002

YRBS data is only collected every other year. Therefore data from 2002 will not be available.

Notes - 2003

Total number of students responding to this question is 3034, which is different than the total of 3048 who participated in this study. For this question 14 students refused to answer.

Notes - 2004

Data not available as yet. Will be available at this time next year.

a. Last Year's Accomplishments

Direct and Enabling
In FY 2002, there were 18,161 visits where emotional concerns were the primary diagnosis in SBHC. This is an increase from last year's visit number of 15,798. These visits were 36% of all primary diagnosis visits. Other diagnoses were tracked when a student comes in for one concern but another concern is also identified. In these cases, there were 29,190 diagnosis made for emotional concerns. In FY 2002, 856 referrals were made to a wide variety of organizations providing crisis intervention, drug/alcohol counseling, and inpatient and outpatient mental health counseling.

There were programs and plans in place to address children who are at risk. However, they are fragmented and not available to reach all children and adolescents in need. For instance, the K-3 Early Intervention Program includes 1 charter school, 55 schools and 13 districts but still cannot reach all the schools and students in need. This program is funded through the Department of Education but is provided by the Department of Services for Children, Youth, and their Families. Another 10 schools have been identified which qualify under criteria regarding the percent eligible for free and reduced school lunch program. However, there is no funding for these.

The DOE provided annual grants to districts to improve student school climate. There were other school climate initiatives, which identify at-risk students and those in need of interpersonal skills development, suicide intervention and prevention, etc. The Division of Child Mental Health is mandated to provide or ensure services to Medicaid eligible (through the Diamond State Health Plan) or uninsured children.

The DCMH also had a variety of programs and initiatives underway to address those children who are already facing crises. The major emphasis in all of DCMHS planning was to increase the availability and accessibility of community-based mental health and substance abuse services as opposed to hospital or residential services. Over the last year, the state reduced utilization of hospital/residential placements.

Finally, DPH, the Department of Education, and others are also seriously looking at the problems faced by gay and lesbian youth as already described.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. School Based Health Centers provide mental health services and referrals for identified adolescents.	X	X		
2. The Division of Child Mental Health has a variety of programs and initiatives underway to address those children who are already facing crises. It also provides funding for the K-3 early intervention program in targeted schools.	X	X		
3. The Dept. of Ed provides annual grants to districts to improve school climate. Other school climate initiatives, which identify at-risk students and those in need of interpersonal skills development, suicide intervention and prevention.			X	X
4. Depression screening is provided as indicated to at risk clients. All individuals exhibiting symptoms are referred for immediate intervention.		X		
5. Middletown School Based Wellness Center (high school) provides mental health counseling services and referrals as needed.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct and Enabling
In FY 2004, there were 18,666 visits where emotional concerns were the primary diagnosis in SBHC. This is an increase from FY 2002 visit number of 18,161. These visits were 34% of all primary diagnosis visits. Other diagnoses are tracked when a student comes in for one concern but another concern is also identified. In these cases, there were 31,631 diagnosis made for emotional concerns. In FY 2004, 1043 referrals were made to a wide variety of organizations providing crisis intervention, drug/alcohol counseling, and inpatient and outpatient mental health counseling.

There are many programs and plans in place to address children who are at risk. However, they are fragmented and not available to reach all children and adolescents in need. For instance, the K-3 Early Intervention Program includes 1 charter school, 55 schools and 13 districts but still cannot reach all the schools and students in need. This program is funded through the Department of Education but is provided by the Department of Services for Children, Youth, and their Families. Another 10 schools have been identified which qualify under criteria regarding the percent eligible for free and reduced school lunch program. However, there is no continued funding for these.

The DOE provides annual grants to districts to improve student school climate. There are other school climate initiatives, which identify at-risk students and those in need of interpersonal skills development, suicide intervention and prevention, etc. The Division of Child Mental Health is

mandated to provide or ensure services to Medicaid eligible (through the Diamond State Health Plan) or uninsured children.

The DCMH also has a variety of programs and initiatives underway to address those children who are already facing crises. The major emphasis in all of DCMHS planning is to increase the availability and accessibility of community-based mental health and substance abuse services as opposed to hospital or residential services. Over the last year the state has reduced utilization of hospital/residential placements.

Finally, DPH, the Department of Education and others are also seriously looking at the problems faced by gay and lesbian youth as already described.

c. Plan for the Coming Year

Enabling Services
The SBHCs will continue to provide mental health interventions and referrals for students who use the centers.

Infrastructure Building
This is another measure for which Title V is not the sole agency responsible for ensuring progress. At this time SBHCs have been the sole mechanism by which we are addressing adolescent mental health concerns. This issue was raised by many informants, other reports, and the data. Although we gathered numerous pieces of information from a variety of sources, there may be resources of which we are not aware. Title V will continue to work with other agencies to put these concerns on the table.

The Delaware YRBS provides the measure -- feeling so sad or hopeless almost every day for two weeks or more in a row that the student stopped doing usual activities -- for this performance measure. There has been no statistically significant change in self reported sadness/hopelessness in the past three YRBS reports. In 1999, the prevalence was 26.9%; in 2001, it was 27%; and in 2003, it was 27.4%. 2005 YRBS data is not yet available from the Delaware Department of Education but will be obtained.

State Performance Measure 4: *Percent of Medicaid eligible children under 3 years who received an initial blood lead screen*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	45	50	50	52	52
Annual Indicator	29.5	31.5	26.4	27.0	26.0
Numerator	3448	3908	4195	4439	4484
Denominator	11694	12394	15875	16449	17241
Is the Data Provisional or Final?				Final	Provisional

	2005	2006	2007	2008	2009
Annual Performance Objective	50	50	50	50	50

Notes - 2003

Comment on Year 2002 data: The Lead Program stated that the 2002 data submitted for the grant was not correct. The numerator for that year should have been 4195;the denominator, 15875; with a resulting 26.4%(not the 42.3%).

a. Last Year's Accomplishments

Enabling

Title V supports a .5 FTE Health Program Coordinator located in Northern Health Services. This position participated on the disease prevention team which tracked non-compliant and delinquent elevated tests, provided case management protocol for elevated lead; and inspected homes for lead. Finally, all DPH programs were expected to determine if there was a need to screen, such as WIC staff who ask about lead screening at the 12-month recertification.

Population Based

On October 28, 2000 the U.S. Department of Housing and Urban Development awarded the State of Delaware, a $2.7 million grant to implement a Lead-Based Paint Hazard Control program. DPH is using the grant for lead-based paint intervention services as part of an overall rehabilitation strategy. The interventions included intensive preventive cleaning to remove lead dust, window replacement, and abatement. DPH partnered with the Latin American Community Center on these initiatives.

Public health staff targeted an educational campaign toward physicians in areas with low percentages of children tested for lead poisoning. In addition, Title V staff continued to work closely with the Offices of Lead Poisoning Prevention and Office of Child Care Licensing to get the word out about lead screening to parents and the child care community.

Following federal guidance from the Centers for Disease Control and Prevention's Childhood Lead Poisoning Prevention Program, the Division of Public Health issued Case Management Standards for Childhood Lead Poisoning Prevention. These were printed and distributed to primary care providers statewide. The purpose for developing the Standards was to describe in detail the essential elements required to provide comprehensive services to families who have children with elevated blood lead levels. The standards apply to a single case manager or a team of health professionals and paraprofessional. One individual was assigned as the case manger and was responsible for assuring that all standards are addressed by themselves or with other team members.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Complete a monitoring plan and form for appropriate case management for the reduction of blood level rates.		X		
2. Conduct outreach and education efforts through community based organizations emphasizing lead poisoning prevention.		X		
3. Targeted education campaign toward physicians in areas with low percentahge of children receiving blood screens.			X	

4. Lead Screening is provided as part of the Child Health/Immunization screening process. School Nurses are very focused on enforcing the requirements of the state law on lead.	**X**	**X**		
5. Lead Screening is provided within immunization clinics according to age and risk factors. Testing kits are provided via federal fund to primate providers servicing high-risk populations.	**X**	**X**		
6. The Public Health Laboratory performs all lead testing.				**X**
7.				
8.				
9.				
10.				

b. Current Activities

Enabling
Delaware established a 5 year strategic plan to eliminate childhood lead poisoning by 2010. The goal is to reduce the incidence of lead poisoning to less than one percent of all children under the age of six.

Delaware provides training to staff of child health clinics on quality control issues such as ways to reduce contamination of samples. Also, we provided training to reporting laboratories on data submission to assure DPH has reliable data for disease surveillance activities.

Population based

DPH distributes lead poisoning prevention information and lead paint test kits in Growing Together packets that are distributed to all new mothers in Delaware's maternity hospitals.

Infrastructure Building:

Delaware received a round of HUD Lead Hazard Control Program funding starting January 1, 2005 to expand lead hazard control activities within target areas of the City of Wilmington.

Delaware continues to provide lead hazard inspections to childcare provides in target areas who are applying or re-applying for licensing through the Office of Child Care Licensing.

c. Plan for the Coming Year

Enabling

Provide information on the risk of childhood lead poisoning, state screening requirements and available health resources to Refugees and Foreign Adoption service agencies in Delaware.

Update childhood lead poisoning prevention educational and outreach materials to include Delaware's Office of Lead Poisoning Prevention (OLPP) telephone number

Population Based

Monitor lead screening of children enrolled in Delaware's health insurance program for uninsured children (CHIPS).

Infrastructure Building

All participating laboratories in blood lead analysis will transfer test result and demographic information via electronic media.

From the DPH Blood Lead Registry, map high risk areas for lead poisoning to the census tract level using Geographic Information System (GIS) geo-coding software.

State Performance Measure 5: *Percent of women delivering live-born infants reporting any cigarette smoking during pregnancy*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	12	12	11.5	11.5	11
Annual Indicator	13.1	13.2	12.9	11.3	11.3
Numerator	1443	1416	1425	1286	1286
Denominator	11046	10747	11083	11337	11337
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	11	10	10	10	10

Notes - 2002

Vital Statistics data for 2002 is not available and will not be available until next year.

Notes - 2003

2003 Data not available at this time. This data will be available at this time next year.

a. Last Year's Accomplishments

Enabling

Counseling regarding smoking continued to be provided during all Family Planning and Pregnancy test visits. Based on need, a client was counseled through Smart Start. All Public Health staff, including Child Development Watch service coordinators, offered health teaching to families they serve and caution against smoking.

Population- Based Services

Public Health clients were referred to Delaware's smoking cessation program called the Delaware Quit-line. The Delaware Quit-Line is a 24-hour, toll-free number staffed by trained tobacco counselors. Callers accessed a smoking cessation program that combines national expertise with local knowledge and service. Those who enrolled received free referrals to specially trained pharmacists and community groups. Vouchers help income-eligible residents access effective pharmaceutical cessation aids.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Public Health clients are referred to Delaware's smoking cessation program called the Delaware Quitline. The Delaware Quitline is a 24-hour, toll-free number staffed by trained tobacco counselors.		X	X	X
2. Counseling regarding smoking is provided during all Family Planning and Pregnancy test visits. Based on need, a client also may be counseled through Smart Start.	X			
3. All Public Health staff, including Child Development Watch service coordinators, offer health teaching to families they serve and caution against smoking.	X	X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Population Based
Referrals will continue to be made to the Delaware Quit-Line.

Direct Services
Counseling regarding smoking continues to be provided during all Family Planning and Pregnancy test visits. Once a woman is determined to be pregnant and, if at risk, she receives services through Smart Start and additional counseling to quit. Other public health staff continues to offer health teaching to families who are receiving services.

Population-Based
The Delaware Tobacco Prevention and Control Program has a focus on several key areas of tobacco control:
1) Community based tobacco prevention efforts
2) Smoking cessation, primarily through a smoking cessation toll-free Quit-Line
3) Social marketing and counter-marketing through the media
4) Promotion and enforcement of policy -- including the state's strict Clean Indoor Air Act and youth access laws.

c. Plan for the Coming Year

Population Based
Referrals will continue to be made to the Delaware Quit-Line.

Direct Services
Counseling regarding smoking will continue to be provided during all Family Planning and Pregnancy test visits. Once a woman is determined to be pregnant and, if at risk, she receives services through Smart Start and additional counseling to quit smoking. Other public health staff will continue to offer health teaching to families who are receiving services.

Population Based

The Delaware Tobacco Prevention and Control Program will continue to focus on several key areas of tobacco control:
Community based tobacco prevention efforts.
Smoking cessation, primarily through a smoking cessation toll-free quit-line.
Social marketing and counter-marketing through the media.
Promotion and enforcement of policy -- including the state's strict Clean Indoor Air Act and youth access laws.

State Performance Measure 6: *The percentage of births to black women in Delaware who have received adequate prenatal care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	65	68	72.2	75	76.4
Annual Indicator	68.2	73.2	74.2	73.4	73.4
Numerator	1796	1977	2008	2102	2102
Denominator	2634	2702	2706	2865	2865
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78.6	80	82	82	82

Notes - 2002
Vital Statistics data for 2002 will not be available until next year.

Notes - 2003
2003 Data not available at this time. This data will be available at this time next year.

a. Last Year's Accomplishments

Enabling Services:
DPH worked to ensure that Smart Start services were provided to all women needing them and to ensure cultural competency. Smart Start is currently under review and being compared to Californian "Black Infant Mortality Project" to determine any needed changes.

Infrastructure Building
Delaware was chosen to participate in the American Public Health Association (APHA) MCH Community Leadership Initiative. The Institute is one of APHA's efforts to address one of its key priority areas - eliminating racial and ethnic disparities. After training in Atlanta team members representing DPH, Christiana Care Health Services, Perinatal Association, and Hill Top Lutheran Neighborhood Center, Inc. developed a method to communicate the issue of disparity in infant mortality. The initial target area was the City of Wilmington. The presentation was developed for use by outreach workers and others from within the community. The main

objective was to communicate with and educate other Delawareans on the issue of the disparity in infant mortality in an effort to build collaborative relationships and buy-in on finding solutions that will make a difference in the future health of Delawareans. During the past year, a presentation was developed and then piloted that is at a level for non-professional lay persons to present and share with their neighbors, churches and other groups in their neighborhoods. This presentation will be available for others to use to continue to educate and encourage further discussion within the community. Funding for presentation packages is being paid for by the March of Dimes.

As already described, the Perinatal Board was the lead to address infant morality and has been paying close attention to addressing the disparity issue. The Board has identified reducing the disparity a top priority and is addressing this issue through the work of the committees. Particularly important, was the work that several members are doing to keep the Healthy Start Consortium going and downstate members who are taking the Perinatal Board disparity conference video to the Kent and Sussex communities.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. DPH is working to ensure that Smart Start services are provided to all women needing them and to ensure cultural competency.			X	X
2. Preparing for a Healthy Baby: a guide to be presented to community groups. The presentation describes the disparity in infant mortality and key activities and lifestyle behaviors that can help to address the situation.			X	
3. DPH provides ongoing support for the Wilmington Healthy Start consortium.				X
4. Prenatal care is continually stressed by both Family Planning and field nurses during home visits.	X	X		
5. A DPH trainer works with Christiana Care to coordinate vitamin distribution and folic acid education program targeted to young adults and women of childbearing age.		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Enabling Services:
DPH isl continuing the Smart Start evaluation and in doing so will review cultural competency issues.

Population-Based
The APHA supported presentation package, called Preparing for a Healthy Baby: a Presentation Guide will be presented to community groups such as the Healthy Start Consortium provider meeting, among others. Members will be able to take the package and present to their constituents. The package includes order and evaluation forms which will be utilized in assessing the interest level of the community and the affect of the presentations.

Infrastructure Building
DPH continues to work hand-in-hand with the Perinatal Board on disparity issues during the Board's transition to become the Healthy Mother and Infant Consortium.

The Family Health Section is very active with the newly established Health Disparities Task Force.

c. Plan for the Coming Year

Enabling Services
DPH will continue the Smart Start evaluation and in doing so will review cultural competency issues. The final report is due in the fall of 2005.

Infrastructure Building

DPH continues to work hand-in-hand with the Perinatal Board on disparity issues during the Board's transition to become the Healthy Mother and Infant Consortium. An interim committee has been established to make the transition and will be working on hte bylaws of the Consortium.

The Family Health Section will continue to be very active with the newly established Health Disparities Task Force.

State Performance Measure 7: *Percent of live births to women who have another birth in less than 18 months*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	9.4	9.3	9.2	9.2	9.2
Annual Indicator	9.0	9.8	10.2	9.2	9.2
Numerator	571	620	673	616	616
Denominator	6375	6311	6601	6691	6691
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	9	9	9	9

Notes - 2002
Vital statistics data for 2002 will not be available until next year.

Notes - 2003

2003 Data not available at this time. This data will be available at this time next year.

a. Last Year's Accomplishments

Direct Services

Family Planning staff counseled clients about potential dangers in having babies at close intervals. They provided other information through pamphlets.

Health teaching was provided by all DPH programs such as Smart Start where families were informed that short birth interval is a risk factor for SIDS (taught in relation to the "Back To Sleep Program").

Population-Based

As already discussed, DPH remained a participant in a project to communicate the disparity to the community. As part of the Preparing for a Healthy Baby: a Presentation Guide, birth spacing was presented. (See State Performance Measure on pregnant black women who receive adequate care for more detail.)

Infrastructure Building:

The Delaware Early Education Council and Prevent Child Abuse Delaware applied for and received funding from the Delaware Children's Trust Fund to develop a demonstration project for Sussex County. It focused on coordinating quality home visiting services to first time families. This project was a consortium of services for first time parents, and not a new program. Goals were to ensure consistent, quality services across all agencies by establishing standards and increasing the capacity of existing programs in the county through training, coordination of services, and filling gaps in services. Birth spacing was included in this service delivery system for first time parents.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support for family planning, Smart Start and Home Visiting program activities ensure that the role of birth interval and infant mortality are communicated.		X	X	
2. DPH participates with the Sussex First Time Families Pilot Project was developed to establish uniform best practices for home visitng programs.				X
3. DPH works with its partners to disseminate the Preparing for a Healthy Baby: A presentation buide to the community leaders in Wilmington. Birth spacing is a key part of the presentation.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct Services

Support for family planning, Smart Start and Home Visiting program activities continue to ensure that the role of birth interval and infant mortality will be communicated. Coordination continues with Resource Mothers to provide outreach and education.

Population-Based Services
DPH continues work with its partners to disseminate the Preparing for a Healthy Baby: a Presentation Guide to the community leaders in Wilmington. The plan is to utilize the skills of community members and the packaged presentation to spread the message.

c. Plan for the Coming Year

Direct Services
Support for family planning, Smart Start, and Home Visiting program activities will ensure that the role of birth interval and infant mortality will be communicated.

Population Based
DPH will work with its partners to disseminate the "Preparing for a Healthy Baby: A Presentation Guide" to the community leaders in Wilmington, Delaware. The plan is to utilize the skills of community members and the packaged presentation to spread the message.

Infrastructure Building
DPH Title V will continue its support for the Delaware Perinatal Board and its activities during its transition to become the Healthy Mother and Infant Consortium.

Title V will continue to play a major role with the establishment of a Maternal and Child Health Center for Excellence as a 'virtual' office in making infant mortality and healthy mothers a priority in the state.

State Performance Measure 8: *The percent of extremely low birth weight black infants among all live births to black women*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	1.7	1.6	1.6	1.5	1.5
Annual Indicator	2.0	1.9	1.8	2.0	2.0
Numerator	250	250	246	266	266
Denominator	12776	13107	13318	13571	13571
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual					

Performance Objective	1.4	1.4	1.4	1.4	1.4

Notes - 2002

Vital statistics data for 2002 will not be available until next year.

Notes - 2003

2003 Data not available at this time. This data will be available at this time next year.

a. Last Year's Accomplishments

Enabling

The Black Infant Health Committee continued to collaborate. However, because most staff had to work on the small pox and bio-terrorism issues, the committee has not met as often as planned. The committee continued to work on improving field services through development of referral guidelines for Smart Start. Brochures have been developed for stress and tummy time. Discussion by the committee has recently centered on whether the committee should have a larger focus and work to improve field services for all clients.

Infrastructure

The Office of Minority Health developed a campaign to address black infant health. Brochures have been developed called Every Child Deserves a First Birthday. These brochures relate the facts that black infants die at a greater rate than white infants do and it is crucial for young women to be conscious of their health. It also provided a list of health style behaviors that would support a healthy pregnancy.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The office of Minority Health developed a campaign to address black infant health. Brochures have been developed called Every Child Deserves a First Birthday.			X	
2. The Black Infant Health Commitee works on improving field services. Brochures have been developed for stress and tummy time.			X	
3. DPH distributes a brochure for Smart Start entitled "Stree During Pregnancy" to help reduce the effects of stress on pregnancy.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Enabling Services

The Black Infant Health Committee discussed with management their recommendation that the Committee be renamed the Field Services Committee which would be assigned to: improve services to clients of all races, keep field service manual current, clarify additions, provide training on changes for current staff and orientation for new staff, and address racial disparities and infant mortality rates and low birth weights on a broader scale by enhancing Smart Start

and Kids Kare with measurable guidelines, e.g. measuring outcomes for Smart Start clients, measuring how many women are educated about preterm labor signs and symptoms.

Population Based Services
The presentation package developed because of the American Public Health Association Maternal Child Health Community Leadership Institute (APHA) is nearly ready for dissemination. Updates need to be made in some of the data provided and it will need to go through a final Division approval process. After that, it will be shared with a variety of community groups and members, who will be asked to do presentations in their communities (i.e., churches, associations).

In addition to disseminating the brochure, the Office of Minority Health's campaign will include a presentation package particularly aimed at black women from a high or middle socio-economic background

The Office of Health Statistics provided an analysis of the increase in infant mortality. The population showing the increase was determined to be a population that Title V does not traditionally serve. The increase was caused by black mothers who were 30 or older, insured, married, have at least a high school education, and receiving care in the first trimester. This analysis, however, does not change the primary risk groups nor does it signify that we need to change our target groups. The Division of Public Health and the Perinatal Board are continuing to analyze the issue. The Division of Public Health has formed an internal work group to study both the increase in infant mortality and any ongoing changes to the population currently serviced. The group is further examining the data with the purpose of specifying target populations and reviewing the programs currently addressing infant health.

Another area that we are examining closely is the disparity between black and white infant mortality during all periods of death, perinatal, neonatal, and post-neonatal. Although it is clear from our studies that improving maternal health is the key in addressing the racial disparity, more research is needed that better describes the socio-cultural, psychological, and behavioral influences on maternal health. Furthermore, more model programs need to be developed specifically for African-American women. Without such research and program development, the disparity will continue to be a problem throughout the nation.

c. Plan for the Coming Year

Enabling Services

The major issues related with racial and ethnic health disparities will be addressed by the newly formed Health Disparities Task Force per the Governor's Executive order. The Family Health Section, along with the Maternal and Child Health Branch and the Adolescent and Adult Health Branch, will be key participants in the Health Disparities Task Force. The goals of the Task Force include: defining the health disparities status of Delaware as compared to the nation and the region; documenting the disparities among racial and ethnic groups related to specific conditions and the reasons for the gaps; identifying best practices for prevention and intervention; increasing awareness of the scope of the problem among government officials, medical professionals and the public; improving coordination between and among the public and private sector; and identifying areas requiring additional research and education.

Population Based Services
The presentation package developed because of the American Public Health Association Maternal Child Health Community Leadership Institute (APHA) will be disseminated.

The Division of Public Health through the Maternal and Child Health Center for Excellence and the newly formed Healthy Mother and Infant Consortium will continue to analyze the issue

State Performance Measure 9: *The rate of children under age 1 who die as a result of Sudden Infant Death Syndrome*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	72.5	70.3	90.1	87	83
Annual Indicator	81.6	90.1	77.6	62.6	62.6
Numerator	43	48	42	41	41
Denominator	52685	53280	54116	65545	65545
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	60	60	60	60

Notes - 2002

Since this is Vital Statistics data, 2002 data will not be available until next year.

Notes - 2003

Vital Statistics data for Year 2003 is not available at this time. It will be available at this time next year.

Notes - 2004

Data not available for 2004

a. Last Year's Accomplishments

Direct and Enabling Services
"Back to Sleep" was emphasized in prenatal and postnatal teaching. DPH staff linked with the Medical Examiner's Office to receive all referrals statewide with pending SIDS diagnosis. Specially trained Title V (MCH) field staff provided home visits to these families to offer support, counseling and follow-up referrals as needed.

Population-Based
Child Care Regulations were being revised to include advice on infants being placed on their backs to sleep. Side sleeping is no longer recommended because the infant can roll onto their stomachs. A meeting was scheduled with the CPR and First Aid trainers for child care providers to discuss how SIDS risk reduction will be incorporated into required training for licensure.

Infrastructure Building
PRAMS 2000 data showed that a large number of infants were still being put to sleep on their stomachs. Only 37% of black mothers, 42% of teen mothers, and 47% of Medicaid eligible mothers were putting their babies on their backs. This information will allow us to better target

the message.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. DPH staff link with the Medical Examiner;s Office to receive referrals statewide with pending SIDS diagnosis. MCH field staff provide home visits to families who have lost an infant due to SIDS.	X	X		
2. Child Care Regulations are being revised that will state that infants will be placed on their backs to sleep. SIDS risk reduction will be incorporated into required training for licensure.			X	X
3. Social work counseling is available statewide for families with a history of SIDS.	X	X		
4. DPH participated in a Delaware FIMR pilot study. Nemours provided medical records review while DPH staff completed the maternal interviews.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct Services

DPH has as a focus on this objective through its clinic and field social workers and nurses who train all new mothers to avoid placing infants on their stomach to sleep.

Infrastructure Building
The Healthy Child Care newsletter informs all childcare providers of the need to put babies on their backs and about the new license requirements.

Delaware agreed to participate in a national survey with the Children's National Medical Center (CNMC) and the Association of SIDS and Infant Mortality Programs (ASIP). The purpose is to provide a database that will:
• Centralize state, regional, and national data so that trends can be detected and tracked.
• Ascertain the effects of the "Back to Sleep" campaign on particular populations at risk (including infants in child care, regional at-risk groups, etc.).
The software was provided but still needs to be installed, which has been delayed due to lack of staff and bio-terrorism priorities.

DPH participated in a Delaware FIMR pilot study from Jan-May 2005.DPH staff together with Child Death, Near Death, and Stillbirth Commission, and Nemours Health and Prevention Services used the FIMR model to review 50 infant deaths from 2003. Stakeholders from many agencies participated in case reviews. Nemours provided medical record review while DPH staff completed the maternal interviews. Information collected will be used to identify gaps in services, provide better coordinated services, and gather lessons for the consideration of a

long term commitment to FIMR.

c. Plan for the Coming Year

Direct Services
DPH will continue to focus on this objective through its clinics, field social workers, and nurses who train all new mothers to avoid placing infants on their stomachs to sleep.

Infrastructure Building
The "Healthy Child Care" newsletter will inform all childcare providers of the need to put babies on their backs and about the new licensing requirements.

Delaware will participate in a national survey with the Children's National Medical Center (CNMC) and the Association of SIDS and Infant Mortality Programs (ASIP). The purpose is to provide a database that will:
? Centralize state, regional, and national data so that trends can be detected and tracked.
? Ascertain the effects of the "Back to Sleep" campaign on particular populations at risk (including infants in childcare, regional at-risk groups, etc.).

Title V and other DPH staff will support the Healthy Mother and Infant Consortium in its efforts to decrease SIDS deaths.

The FIMR project will continue.

State Performance Measure 10: *Hospital discharge rate for children from five through 17 years with asthma*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	20.3	20.3	20.3	20.3	19.3
Annual Indicator	19.2	18.1	17.8	19.7	19.7
Numerator	1335	262	260	288	288
Denominator	694995	144848	145735	146338	146338
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	17	17	17	17	17

Notes - 2002

Delaware's Office of Health Statistics has lost several key employees and do not at this time have the capacity to provide hospital discharge data. No estimate can be provided as to when

this information will be available.

Notes - 2003

2003 Data is based upon the number of hospital discharges with principal diagnosis of asthma.

Notes - 2004

2004 Data not available

a. Last Year's Accomplishments

Title V staff had a leadership role to play in this area through 1) education regarding second hand smoke and asthma; 2) support for Kids Kare; 3) collaboration with duPont Pediatric Clinics and the American Lung Association on their efforts; 4) continual support for medical homes; and 5) the provision of information and training to child care providers.

Enabling

DPH provided liaison activities at hospitals to assure linkage with a primary health care home and other needed resources in the community (i.e., Medicaid, Delaware Lung Association, Public Health Nursing, Home Health Care Agencies). These activities were a result of the collaboration with the A.I.duPont clinics and the community based organizations.

Infrastructure Building

During the past years, DPH coordinated with the Office of Child Care Licensing to provide additional information on asthma to child care providers. Several of the evaluations from those classes recommended a full class on asthma specifically information on managing asthma and the treatments (i.e. nebulizers, etc.) As a result, a new module, based solely on asthma management was offered this past year.

The Department of Education had conducted a Chronic Illness Survey. The report covered 82,245 students in Delaware primary and secondary schools. The majority (64%) of these students went to schools in New Castle County; 21% and 15% went to Kent and Sussex County schools, respectively. The schools reported large numbers of students with specific chronic conditions. Among the most commonly reported was asthma. The statewide reported prevalence of asthma in school students was 8%. Prevalence did not differ significantly among the counties, but rates were higher among pre kindergarten (11.5%) and elementary (8.3%) than in intermediate and high school students. There was wide variation in prevalence among schools but a much smaller variation among school districts. The median reported rate among schools was 8.0%. The Centers for Disease Control estimated the national asthma prevalence rate for persons 5-14 years old in 1994 to be 7.4%, with a significant increasing trend since 1980, and substantial regional variation. Reported rates in Delaware schools are consistent with this national estimate. Although this survey did not obtain detailed demographic information for each school, it is likely that the male: female ratio among students statewide is near 1. In that case, there appears to be a substantial excess of reported male students with asthma over the female rate, consistent with published studies.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. DPH to collaborate with the Lung Association and the DuPont Pediatric Clinis on their asthma reduction efforts.		X	X	
2. Education of the child care providers utilizing the asthma teaching model is ongoing.			X	
3. The recent Department of Education report on chronic diseases which				X

included asthma will be reviewed and studied for its implications.				
4. Home visits stress the importance of avoiding smoking in the presence of the baby - due to damage caused by second hand smoke.	X	X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure
The Department of Education Chronic Disease Survey results were reviewed and analyzed by MCH staff. The Coordinating Council for Children with Disabilities also reviewed the results of the survey.

The Division of Public Health does not currently have an asthma program. However, the Division's Health Promotion and Disease Prevention Section worked jointly with the state's Department of Natural Resources and Environmental Control to produce a Burden of Asthma in Delaware report. In addition, an application was being prepared for funding two Delaware communities through the Steps to a Healthier US grant program, which includes enhancement of asthma education and prevention.

Delaware's Behavioral Risk Factor Survey has been collecting data on asthma since 2000, in preparation for the Burden of Asthma report and development of an asthma program when funding becomes available. In the 2002 BRFSS, 14% of Delaware adults reported they had been told by a doctor or health professional that they had asthma at some time in their lives. A 2003 child asthma supplement to the BRFS indicated that approximately 45,000 households in Delaware have at least one child with diagnosed asthma. In 2004, about 14.4% of Delaware adults reported having been told by a doctor or health professional that they had ever had asthma. About 10% of the state's adult population reported currently having asthma.

c. Plan for the Coming Year

Enabling
DPH liaison activities will continue at hospitals to assure linkage with a primary health care home and other needed resources in the community (i.e., Medicaid, Delaware Lung Association, Public Health Nursing, Home Health Care Agencies).

Infrastructure Building
DPH will continue to coordinate with the Office of Child Care Licensing to provide information on asthma to child care providers. The new teaching module, based solely on asthma management will again be provided during the upcoming year to all child care providers in the home and facilities.

The Burden of Asthma in Delaware report has been completed, and will be published during the summer of 2005.

E. OTHER PROGRAM ACTIVITIES

In February 1997, the state launched an expanded partnership with the Delaware Helpline, a non-

profit information and referral service administered by United Way. The toll-free service employs fully trained specialists to provide current information about and referrals to state and non-profit services. Included in Helpline information are details on services regarding maternal and child health programs. Delaware Helpline is available as an online service at www.Delawarehelpline.org.

The Family Health section operates another toll free line which provides up-to-date health information for teens and adults. An individual can call In Touch 24 hours a day, 7 days a week and listen to pre-recorded information on over 300 topics in the following categories: AIDS, Family Planning, Reproductive Health Care, Pregnancy/Options/Prenatal Care, Rape/Sexual Harassment, Sexuality, STDs, Safety, Messages for Older People, Alcohol, Cocaine, Marijuana, Other drugs, Reasons for Young People to say No, Tobacco, Mental Health, Stress, and Depression, Health and Fitness, Nutrition, Diet and Weight Control, Parenting, School Issues, Self-Esteem, Assessment and Help, and Personal Growth.

Coordination
EPSDT is administered through Medicaid. Services are now delivered through Medicaid's MCOs. As of October 1, 2003 Medicaid took over management of one of the managed care plans. DPH provides some EPSDT services and works with Medicaid to ensure access to care.

Title V and the WIC program have many opportunities to consolidate policies and services. Several common objectives and joint activities have already been listed. The WIC program has been organizationally moved to the Health Promotion and Disease Prevention Section. Communication and coordination between Title V and the WIC program will continue as in the past.

IDEA is implemented through DPH's Child Development Watch program. Grant administration is through the Division of Management Services, which is part of Department of Health and Social Services. Family Planning (Title X) as discussed is part of the Community Health Care Access Section. The Family Planning Director reports to the Director of Adolescent and Adult Health in the Family Health Section.

DPH has many opportunities for coordination and collaboration with providers of services to identify pregnant women and infants who are eligible for Title XIX to assist them in applying for services. As described earlier, we actually have stationed staff in hospitals and physician's offices. Included in collaborative efforts are outreach efforts for Medicaid and the Delaware Healthy Children program, the development of the Early Childhood Comprehensive System plan.

A DVR representative has been attending the Brain Injury Committee of the State Council for Persons with Disabilities. Efforts are also being extended to include representatives from the Social Security Administration and the State Disabilities Determination Services unit on the CCCD.

As is already described and well known to those familiar with the block grant, it has been level funded for several years. The state also pays for about 33 FTEs with the grant. Every time salaries are raised, there is a decrease of available dollars. We have not just matched the dollars allotted through the grant but provide an overmatch. Another way that we have addressed needs is to collaborate with other agencies, both public and private.

F. TECHNICAL ASSISTANCE

While the past State's needs assessment process has been conducted in a multi-faceted manner (i.e., reviewing existing reports, surveys, careful examination of data, discussions with professional and community leaders and groups and clients), there is a need to more fully examine overall program capacity. The state is asking for continued technical assistance at this time to implement the CAST-5 comprehensive assessment of program capacity needs. The request for technical assistance is to acquire a consultant with extensive experience in implementing the CAST-5 process for Maternal Child Health Services to assist the Division of Public Health and Family Health Section in specifically tailoring the CAST-5 process to the State's specific requirements.

The state is also asking for technical assistance to design an efficient system for tracking personnel hours and activities performed in the following maternal and child health areas: Pregnant Women, Mothers, and Infants, Children and Adolescents, and Children with Special Health Care Needs. Technical assistance would include identification of best practices, exploration of options for creating a system, development, implementation, and testing/evaluation of the system.

V. BUDGET NARRATIVE

A. EXPENDITURES

The State maintains budget documentation for Block Grant funding/expenditures for reporting consistent with requirements.

B. BUDGET

The maintenance of effort remains the same with the State of Delaware continuing to provide an overmatch of which is much greater than its maintenance of effort. The total match is $8,943,761. It is made up of school based health center contract funds and salary/benefit dollars for positions providing Kids Kare, Child Development Watch, Smart Start and MCH administration. The match (including maintenance of efforts funds)is funded through state general funds. "Other" dollars are from the Newborn Screening Program. The federal support complements the state efforts for the already existing MCH programs listed above.

The increased funding for the application year is necessary given the increase in costs for health care insurance and other fringe benefits. In the past years, as state funded workers received a raise so did federally funded workers. As most of the grant is allotted for positions the past years of pay raises have taken its toll on the restricted budget.

The application's budget includes: $2,012,563 for salaries and fringe benefits; $60,382 for contractual services; $232,999 for indirect costs and $6,000 for travel, supplies duplication costs, telephones, etc.; and $4,176 for audit fees. The budget forms provide more detailed explanation. The total federal budget is for $2,316,120. $717,997 is provided for preventive and primary care for children. $694,836 is provided for children with special health care needs. Match is based on salary/benefits dollars allotted to personnel providing services to those populations and on a proportion of dollars allotted to support those positions.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.